NATIONAL LABOR RELATIONS BOARD

REGION SEVEN

In the Matter of:

OAKWOOD HEALTHCARE, INC.,

Employer

and

Case No. 7-RC-22141

INTERNATIONAL UNION UNITED
AUTOMOBILE AEROSPACE AND
AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW,

Petitioner.
_____/

REQUEST FOR REVIEW

OAKWOOD HEALTHCARE, INC.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

INTRODUCTION

Oakwood Healthcare, Inc. ("OHI" or "Employer"), by its attorneys, Dykema Gossett PLLC, and pursuant to Section 102.67 of the Board's Rules and Regulations, requests review of the Decision of the Regional Director, dated February 4, 2002 ("Dec."), holding that the Employer's charge nurses are not supervisors under the Act and directing an election in a single-facility bargaining unit comprised of certain registered nurses at Oakwood Hospital Heritage Center ("Heritage"). (Ex. A).

This Request for Review is made for the following reasons: (1) many of the Regional Director's findings regarding substantial factual issues are clearly erroneous and prejudicially affect the Employer's rights; (2) the Decision of the Regional Director raises substantial questions of law and policy because of its departure from officially reported Board precedent; and (3) there are compelling reasons to reconsider and clarify important Board policy in this area.

NATURE OF THE CASE

On December 21, 2001, the International Union United Automobile Aerospace and Agricultural Implement Workers of America, UAW ("Union" or "UAW") filed a representation petition seeking to represent certain registered nurses at Heritage (one of four acute care hospitals owned and operated by the Employer). The representation hearing was held in this matter on January 9-11, 2002. At the hearing, OHI maintained that the appropriate bargaining unit is a multi-facility unit consisting of all four of its acute care hospitals: Heritage, Oakwood Hospital and Medical Center-Dearborn ("Dearborn"), Oakwood Hospital Annapolis Center ("Annapolis"),

and Oakwood Hospital Seaway Center ("Seaway").[1] The UAW contended that the petitioned-for single-facility bargaining unit limited to Heritage is appropriate.

OHI also maintained that some or all of the registered nurses at Heritage are supervisors within the meaning of Section 2(11) of the Act and are thereby excluded from a bargaining unit of registered nurses. The Union argued that none of the petitioned-for registered nurses are supervisors within the meaning of the Act.

The Decision of the Regional Director holds (1) that the Employer's charge nurses are employees and includes them in the petitioned-for RN unit, and (2) that a single-facility bargaining unit comprised of registered nurses at Heritage is appropriate. The Employer requests review as to these findings.[2]

ARGUMENT

I. THE REGIONAL DIRECTOR INCORRECTLY HELD THAT THE EMPLOYER'S CHARGE NURSES ARE NOT SUPERVISORS UNDER THE ACT

A. Substantial Factual Determinations Are Clearly Erroneous and Prejudicially Affect the Employer's Rights

The Decision of the Regional Director fails to consider several facts which clearly demonstrate that the Employer's charge nurses are supervisors. These errors and omissions,

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[1]On March 5, 2001, Local 79, Service Employees International Union, AFL-CIO ("SEIU"), filed a petition in Case No. 7-RC-21970, seeking to represent the registered nurses employed at Annapolis. A hearing was held to determine whether the appropriate unit was one consisting of all four of the Employer's acute care hospitals. On May 9, 2001, the Regional Director issued his Decision, holding that, although a unit of the Employer's four acute care hospitals "may be appropriate," the petitioned-for single facility unit was not inappropriate. (Ex. B). Before the Employer's Request for Review was considered by the Board, the SEIU withdrew its petition. In the instant case, the hearing officer took administrative notice of the entire record in Case No. 7-RC-21970, incorporating it herein.

[2]For ease of reference, the Employer will refer to the transcript in the prior case, Case No. 7-RC-21970, as "Annap. Tr. at __" and the record in this case as "Tr. at __." Exhibits in Case No. 7-RC-21970 will be cited at "Annap. ER-____" (Employer exhibits), "Annap. P-___" (Petitioner exhibits), and "Annap. JT-____" (Joint Exhibits). Exhibits made part of the record in the instant case will be referred to as "ER-____" (Employer exhibits), "P-___" (Petitioner exhibits), and "JT-_____" (Joint exhibits).

discussed below, prejudicially affect the rights of the Employer, necessitating review and reversal of this portion of the Decision.

1. Nursing Department Structure

For the most part, the Decision of the Regional Director correctly states the organizational structure of Heritage's nursing department. As set forth in the Decision, Heritage is one of four acute care hospitals owned and operated by OHI, a Michigan corporation. (Dec. 2). Heritage is a 257-bed, licensed acute care hospital located in Taylor, Michigan. (Dec. 4). Brenda Theisen ("Theisen"), the Nursing Site Leader and Director of Patient Care Services at Heritage, has overall responsibility for all aspects of nursing care at Heritage and reports directly to Barbara Medvec, the Chief Nursing Officer for the entire OHI system. (Dec. 6).

Reporting directly to Theisen are Heritage's clinical supervisors and clinical managers, along with various other non-nursing department heads. (Dec. 6). Below the clinical managers are assistant clinical managers, charge nurses, and other staff,[3] as indicated below:

Nursing Site Leader
↑
Clinical Manager
↑
Assistant Clinical Manager
↑
Charge Nurse
↑
Staff

As the Decision of the Regional Director recognizes, the responsibilities of the Nursing Site Leader, the clinical managers, and the assistant clinical managers do not include the day-to-day, hands-on supervision of the Hospital's various nursing units. (Dec. 6-7). Theisen, the

[3] "Staff" refers to all individuals who are supervised by charge nurses, including registered nurses (RN), licensed practical nurses (LPN), nursing assistants, mental health workers, emergency room techs, paramedics, and desk secretaries.

Nursing Site Leader at Heritage, spends only about thirty minutes per day on the nursing units and plays no role in directly supervising the nursing personnel responsible for providing care on the units. (Dec. 6). Heritage's clinical managers (who work the day shift) engage in virtually no clinical work, instead devoting the majority of their time to administrative concerns such as formulating policy, developing budgets, scheduling, and attending meetings. (Dec. 7). These individuals dress in street clothes, are paid on a salary basis, and, for all intents and purposes, have only the broadest oversight responsibility for their units. Similarly, assistant clinical managers also engage in little or no clinical work, instead functioning as "part of the management team" and sharing responsibility for the clinical managers' scheduling, budgeting, and other administrative duties. (Dec. 7).

Heritage also employs clinical supervisors (a.k.a. "house supervisors"). (Dec. 6). These individuals only work on the off shifts, i.e., afternoons, midnights, weekends, and holidays. (Dec. 6). Only one clinical supervisor is on duty on each such shift, and that person is responsible for the entire hospital, meaning both nursing and non-nursing areas. (Dec. 6). When on duty, the clinical supervisor is the highest-ranking administrative representative in the entire Hospital. (Dec. 6).

2. *Responsibilities of Charge Nurses*

a. Generally

Although the Regional Director concedes that the administrative responsibilities of Heritage's Nursing Site Leader, clinical supervisors, clinical managers, and assistant clinical managers leave them little time to engage in day-to-day supervision of the Hospital's various nursing units, the Decision fails to recognize the extent to which Heritage relies on its charge nurses to supervise its staff RNs, LPNs, nursing assistants, mental health workers, and others.

Charge nurses cover all three shifts, seven days per week and, on off shifts, are the highest ranking nursing personnel on the nursing units. Charge nurses are paid a premium – $1.50 per hour – for time spent in that role in order to compensate for "the stress of the job" and the fact that the charge nurse job "is a difficult job to do." (Tr. 102).

The Decision makes little mention of the broad, supervisory responsibility vested in Heritage's charge nurses. When asked about the expectations and the functions of charge nurses at Heritage, Theisen said:

> . . . generally they oversee the unit for the shift that they are working with the staff who are working the unit that day. They do the assignment of all the staff that are working on that shift. They monitor in general all the patients that are in the unit that day, are kind of front line to meet with Physicians if we have a Physician who has an issue with the Nurse or with a patient. They are the front line if we have a patient or a family member with a complaint.

(Tr. 74-75). Thus, on any given day, while clinical managers and assistant clinical managers are busy attending to the administrative concerns of their multiple units, charge nurses are responsible for ensuring the proper functioning of their individual nursing units.

Significantly, the Decision does not even mention the fact that, over time, several documents have been developed at Heritage to define the roles of the charge nurse. These documents were entered into evidence as ER-4 and ER-5(a)-(d) (attached as Ex. C). Employer 4 is a draft hospital-wide Charge Nurse Policy. As the testimony established, ER-4 is a codification of previous charge nurse policies and practices in force at Heritage. Both ER-4 and the various longstanding charge nurse policies (ER-5) list similar expectations of the Heritage charge nurses, including the assignment and direction of staff:

- "Responsible for staff assignments, bed assignments, and breaks/lunches for staff" (ER-4);
- "Make daily patient assignments to RNs, LPNs and NA and Secretary" (ER-5(a));

- "Remember you are the first step in the chain of command" (ER-5(a));
- "Assign break times for all staff members and provide coverage as needed" (ER-5(a))
- "Assigns patient care assignments according to staff's job description, competency, and patient's acuity"(ER-5(b), 5(c));
- "Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel" (ER-5(b), 5(c));
- "Assigns break/lunch periods" (ER-5(b), 5(c));
- "Determine patient care assignments for RN, LPN, GN, NE and NA with consideration to staff capabilities/competence" (ER-5(d));
- "Assign RN coverage for LPN, NE and GN" (ER-5(d));
- "Assign breaks and lunches to maintain adequate patient coverage" (ER-5(d)).

b. Charge Nurses Assign and Responsibly Direct the Nursing Staff and Do So With Independent Judgment

The Regional Director devotes a significant portion of his Decision to an analysis of the charge nurses' authority to assign and responsibly direct subordinate staff. The Decision correctly concludes that Heritage's charge nurses are responsible for the assignment and direction of the RNs, LPNs, mental health workers, nursing assistants, and other personnel on the unit. (Dec. 11). **Moreover, the Decision recognizes that this responsibility includes assigning and reassigning staff to patients, assigning admissions, transfers, and discharges, assigning breaks and lunches, and assigning any additional unit-specific tasks that need to be performed during the course of a day.** (Dec. 13-15). Beyond this, however, there are a number of inaccuracies in the factual conclusions drawn by the Regional Director.

(1) Charge Nurses Assign Staff to Care for Patients

The Regional Director appropriately acknowledges the primary responsibility of charge nurses at Heritage, which is to assign staff to patients at the beginning of a shift and to adjust this

assignment as necessary. (Dec. 13). **The Decision further recognizes that, in making out the daily assignment, the charge nurse must considers various factors, including patient acuity, employee interest, employee ability, personality, and experience.** (Dec. 13). The way in which these factors influence a charge nurse's decision-making process on a daily basis was explained by several witnesses. For example, Carol Carney, the assistant clinical manager for the Behavioral Health unit, described several considerations (in addition to patient acuity) that may play into the charge nurse's assignment:

- "For instance, if we have an aggressive male, then [the charge nurse] may want a male mental health worker to take care of him." (Tr. 302).
- ". . . if it's a patient that has medical problems, [the charge nurse] might assign that patient to an RN." (Tr. 303).
- ". . . if the staff has a good rapport with the patient, then that would be the staff that [the charge nurse] would assign, generally." (Tr. 304).
- ". . . [the charge nurse] considers the patient's behavior from what she has gotten from report. She considers what staff might work best with those patients, taking their behavior into consideration. Like, if it was a female patient that was sexually preoccupied, she would give that patient to a female staff." (Tr. 305).
- "Often, it's also a matter of their ethnic background. Even we have Arabic patients, so, sometimes, if we have an Arabic staff, obviously, [the charge nurse] would assign the Arabic staff to that patient so they can communicate back and forth." (Tr. 307).

Likewise, Sue Caines, the clinical manager for Med/Surg West and Med/Surg East, indicated that charge nurses on her units must consider factors such as patient acuity and staff competency in making assignments. Caines further explained how charge nurses must use independent judgment in assessing and reacting to these variables:

> I believe [the charge nurses] need to assign the patient care – assign patient care according to staff's job description, competency, and the patient acuity.

* * *

> As far as the staff's competency, again, I referred to sometimes we have pediatric patients, sometimes we have chemo patients, sometimes we have orthopedic patients that need special care and those that have had special training would be the ones you would want to have assigned to those patients.
>
> And then the patient's acuity. You have to take that into effect, again, because you want a fair assignment. Some may have four patients. Some may have five patients, but it would still be a fair assignment based on the acuity of the patient or the needs that they're presenting that they need to have cared for. (Tr. 381).

The Regional Director recognizes that the role and responsibilities of the charge nurse in making staff assignments is well-documented in the Employer's policies. (Dec. 13). Specifically, ER-6 (Assignment of Patients) and ER-7 (Assignment of Nursing Personnel) (attached as Ex. D) describe in detail both the charge nurses' role in assignment and the factors they must consider in doing so. ER-6 states:

> 4.1 B. Assistant Nurse Manager/Charge Nurse (assigned by the Nurse Manager) assigns/delegates care needs based on the ability of the patient to do self care, degree of illness, complexity of nursing skills required, and the competency and qualifications of staff.

ER-7 contains the following:

> II. C. Patient care assignments are made by the Clinical Manager or the Registered Nurse in charge for that shift. Assignment will be reviewed on an ongoing basis and changes made in response to the patients' changing conditions.
>
> II. D. The assignment of the patient takes into consideration the acuity level and clinical needs as identified by the Acuity System and the clinical assessment by the Charge Nurse. The patient's acuity is used to determine the level of skill required to care for the patient.
>
> III.B.1. The Charge Nurse will meet with the assigned staff to review patient condition and care activities to be completed for that shift.
>
> 2. Specific patient care tasks will be assigned based on competencies and classification of the staff, and care required.

As the Regional Director notes, Section III.C. of ER-7 sets forth detailed criteria that must be independently evaluated and applied when a charge nurse makes an assignment. (Dec. 13).

Even the two UAW witnesses, who went to great lengths to mischaracterize the life and death assignment decisions attendant to the care of critically ill patients in an acute care hospital as involving nothing more than viewing the Hospital's patients as a "pie" and mechanically dividing that pie up among the staff, were forced to concede on cross-examination that this is not the case. Thus, the testimony of both Employer and Union witnesses clearly establishes that charge nurses are responsible for using independent judgment in assigning and reassigning the nursing personnel on their units.

Despite extensive testimony on the intricacies of the assignment process, and despite his own recognition of the numerous factors to be considered by charge nurses in assigning patients to staff, the Regional Director improperly minimizes the import of this function, saying:

> The assignment of staff nurses to patients is much more perfunctory in practice than the Employer's written assignment policy indicates. The assignment of work is generally rotated, or based on where a person worked the previous day. When making assignments as a charge nurse, reference is made to a staffing sheet showing where everyone worked the day before. It usually takes only a few minutes to do the assignments.

(Dec. 14). This statement is simply untrue and is based entirely on the testimony of one UAW witness, who testified only about the day shift in the Emergency Department.

Carol Welch, a UAW witness who works part-time in the Emergency Department, testified as to the manner in which she, an Emergency Room charge nurse on the day shift, assigns staff. Concededly, the assignment of staff in that area is quite different than in other areas of the hospital, particularly on the day shift. In the Emergency Department, a "geographic" assignment is possible, as the Department consists of a small geographic area and all patients are presumed to be highly acute. And, as Welch admitted, the most common reassignment in the Emergency Department – from the Emergency Department to the "quick care" area and vice versa – occurs only on the afternoon and midnight shifts, so she would have no knowledge of

such occurrences.[4] (Tr. 525-26). Thus, although the Regional Director's description of the assignment process may accurately summarize the testimony of a single UAW witness, who based on her experience as a part-time nurse, was testifying about the functioning of the unique Emergency Department on a single shift, it was a crucial error for the Regional Director to extrapolate this process to other areas of the Hospital.

The Decision of the Regional Director also downplays the way in which charge nurses in the Intermediate Care Unit ("IMC") assign patients to staff, saying:

> When the nurses arrive for their shifts in the [IMC], they all listen to the report from the charge nurse of the previous shift. Then the charge nurse makes the assignments by asking who knows which patients have the highest acuity (these patients are referred to as the "completes"). They get a slip from the staffing office showing who is supposed to be there that day. The charge nurse then makes out the assignments. First, the completes are divided up evenly. After that, they look at who was there the day before, and try to give them the same assignment they had in order to maintain continuity.

(Dec. 14). This description of the blithe manner in which IMC charge nurses assign patients to staff flies in the face of the testimony of UAW witness Nancy Coffee, who admitted:

- That in assigning and reassigning staff, she considers factors such as patient acuity, employee workload, admissions, transfers, and employee skill. (Tr. 593, 602).
- That, when assigning staff to patients, she considers the varying skills and training of her staff. (Tr. 602-03). Specifically, when assigned flex pool staff or staff pulled from another unit, these individuals would "have to be [assigned to] someone who is not a cardiac patient and someone who is not on any drips like nitroglycerin or cardizone or any drips that they are not trained for." (Tr. 602).

Thus, the Regional Director's characterization of the assignment process in IMC as one involving little independent judgment is belied by the testimony of several witnesses.

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[4]Moreover, Welch's testimony was inconsistent with that of Debbie Vogel, the assistant clinical manager in the Emergency Department. Vogel testified that the Emergency Department's charge nurses are responsible for assigning patients to staff (considering any variation in staff abilities), reassigning personnel between the main Emergency Department and the quick care area as needed, and assigning and/or covering breaks and lunches. (Tr. 465-67).

(2) Charge Nurses Reassign Staff as Necessary

Although the Decision of the Regional Director appears to recognize that charge nurses commonly step in and reassign employees throughout the course of a shift (Dec. 13-14), the Decision incorrectly minimizes the authority of the charge nurses in this regard, saying:

> Furthermore, RNs usually work together to help each other out, as a common courtesy of their profession. If RNs need help with a patient, they may go directly to another nurse and ask rather than going to the charge nurse.

(Dec. 14). Although it may be true that nurses are working with each other (as opposed to against each other), the fact remains that it is Heritage's charge nurses who are responsible for making necessary reassignments. (Dec. 14).

In order to assess whether reassignment is necessary, the charge nurse must observe and evaluate how her staff are performing their assignments and anticipate any fluctuations in workload. If a staff nurse (or other nursing personnel) experiences a change necessitating reassignment (such as an unexpected admission, discharge, or change in patient acuity), she knows to approach the charge nurse and inform her of the changing circumstances. (Dec. 14). At that point, the charge nurse is responsible for assessing the situation and making an informed decision as to whether reassignment is necessary and, if so, what that reassignment should be. (Dec. 14). Nursing Site Leader Brenda Theisen explained how this process works in practice:

> Q. What circumstances might lead to this person becoming unhappy or a staff member becoming unhappy about an assignment?
>
> A. Could be the feeling that well maybe the Charge Nurse didn't really realize how heavy a patient this was going to be or something is going on with the patient that is new, maybe a new medication that is being ordered that is going to keep them tied up with a patient for a length of time and they don't think the Charge Nurse has given allowance for the amount of time that they are going to be tied up with that particular patient.
>
> Q. If that staff member complains to the Charge Nurse must the Charge Nurse change the assignment?

A. No, they must make an intelligent decision about whether or not it needs to be changed though.

(Tr. 115-16). Thus, the fact that the nurses work together to adequately care for patients does not diminish the fact that it is the sole responsibility of the charge nurse to consider and decide upon any reassignment.

(3) Charge Nurses Assign and Alter Employee Breaks and Lunches

The Decision of the Regional Director correctly recognizes that, in addition to the assignment of nursing personnel, Heritage's charge nurses also are responsible for assigning breaks and lunches. (Dec. 20). The Regional Director minimizes the import of this function, however, by saying that, ". . . the charge nurse generally sets up the break times in order to ensure coverage on the floor, and receives input from the nursing staff as to when they would like to take their break." (Dec. 20). Although not wholly inaccurate, this statement downplays the role of Heritage's charge nurses in the smooth functioning of the Employer's operation.

Like any operation, there are preferred times for breaks at Heritage, but because of the nature of an acute care hospital, the determination of break and lunch times is a matter of sound supervisory judgment and is not left up to individual staff members. As conditions change, the charge nurse retains both the responsibility and the authority to juggle breaks and lunches as needed to ensure adequate patient care. (Tr. 250, 384). Moreover, when a staff member leaves the floor for a break or lunch, she is required to notify her charge nurse. (Tr. 315).

(4) Charge Nurses Assign Other Tasks as Necessary

The record testimony demonstrates that charge nurses also are responsible for ensuring that certain tasks are completed on each shift, a fact that the Decision conspicuously fails to mention. Depending on the unit, these tasks may include completing narcotics counts, checking

the "crash cart," attending shift report and interdisciplinary rounds, and maintaining data on falls and restraints. (Tr. 91-95, ER-4, ER-5) (attached as Ex. C). With respect to each of these tasks, the charge nurse is responsible for either doing them herself or assigning them to another staff member. (Tr. 92). UAW witness Nancy Coffee explained how this works:

> Q. Your assignment sheet. Those duties to be assigned listed at the bottom there, those are the duties that you assign as charge nurse, correct?
>
> A. If the charge nurse does not have patients, she does them herself.
>
> Q. Okay. And if the charge has patients, she assigns them to the other RN's?
>
> A. Yes.

(Tr. 584). Thus, although the charge nurse may assign these tasks to other staff members she is ultimately responsible for assuring that all of the tasks are completed on her shift.

(5) Charge Nurses Are Held Accountable for the Performance of Their Staff/Units

The Decision of the Regional Director concludes that, "The RNs do not evaluate the work of the less skilled employees or ensure that they have completed a task or done so correctly." (Dec. 20). Although it is true that charge nurses do not complete performance evaluations for other employees, the Decision is wholly incorrect in concluding that Heritage's charge nurses are not held accountable for the performance of their unit staff. Nursing Site Leader Brenda Theisen testified as follows:

> Q. As the Nursing Site Leader, as the person responsible for all the Nursing operations, who is the person in your estimation that is directly responsible for the day to day functioning of the staff on the Nursing units?
>
> A. The Charge Nurse.

(Tr. 128). Assistant clinical manager Carol Carney also testified that she views the charge nurse as the person ultimately responsible for her unit's performance on a given shift:

Q. Once the charge nurse makes out the assignment at the beginning of the shift, does she maintain any kind of ultimate responsibility for seeing that everything gets done according to plan on the shift?

A. Yes, she does.

Q. And, as the assistant clinical manager, is she the one you'd hold responsible if everything didn't get done on a given shift?

A. Yes. (Tr. 319).

Further, the Regional Director concedes that, in their annual performance appraisals, nurses are evaluated on their "leadership" skills and, specifically, on their performance as a charge nurse. (Dec. 10-11). This fact was acknowledged by the testimony of each and every witness at the representation hearing (including those witnesses called by the UAW).[5] For example:

- Brenda Theisen testified that a nurse's performance as charge nurse is evaluated when determining whether that nurse has demonstrated "effective leadership." (Tr. 195).
- UAW witness Nancy Coffee admitted that her performance as a charge nurse has been discussed at her annual performance evaluations and figures into her "leadership" rating. (Tr. 589-90).

Clearly, the Regional Director's factual finding on this point should have compelled a conclusion that charge nurses are held accountable for their performance in that role.

Finally, the Regional Director's Decision ignores the fact that charge nurses can be disciplined for poor performance of their assignment function, and that this has, in fact, happened. (Tr. 98). When asked to give an example of this occurring, Theisen explained:

> Staff from a unit [went to] the manager and complained that they didn't feel as though the assignment had been done fairly, that some people were given a heavier assignment than others.

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[5]Although one of the union's witnesses, Carol Welch, initially denied that her performance as charge nurse had ever been mentioned during the course of a performance appraisal, she was forced to admit on cross examination that this had, in fact, happened on more than one occasion. (Tr. 548-49, ER-15, 16).

* * *

The Nurse Manager met with the Nurse who had been in charge and reviewed the assignment, pointed out what was inappropriate about it, wrote it into a discipline.

(Tr. 98-99). Similarly, a charge nurse can be disciplined if she otherwise fails to perform those duties required of her as a charge. Theisen recounted one such example:

A. There was an example on one of our units on afternoon shift where the Supervisor was in a crisis situation in the ER and called to a Charge Nurse in a unit and said I need you to come or to send someone to the ER to help us we are in a crisis. And the person didn't send anyone, turned around to staff and said oh, they are calling, they want somebody to go to ER, just kind of a general statement, didn't assign anyone to go, didn't go herself and there was a crisis that was a serious situation going on in the ER so there was a disciplinary action.

Q. Do you recall the level of the discipline?

A. It was a suspension.

Thus, charge nurses are held accountable if their assignments (or the performance of their staff) are not sufficient to ensure the completion of all necessary tasks on a shift.

c. Charge Nurses Do Substantially Less Patient Care than Staff Nurses

As the Regional Director recognizes, nearly all of Heritage's charge nurses take a substantially lighter patient load than that of a staff RN. (Dec. 14). However, the Regional Director fails to mention that many charge nurses take no patient assignment at all. Tellingly, the charge nurses themselves are responsible for determining whether they will take a patient load on any given day and, if so, how heavy that load will be. (Dec. 14). UAW witness Nancy Coffee admitted that, when functioning as a charge nurse, she is solely responsible for determining her patient load on a given day and, in fact, as charge nurse, she typically has a lighter patient load than the staff RNs on her unit. (Tr. 585). These facts should have compelled the Regional

Director to conclude that Heritage's charge nurses, though working supervisors, do substantially less patient care than they assign to the staff RNs working under them.

d. Charge Nurses Adjust Grievances

In response to significant evidence establishing the role of charge nurses in addressing and resolving employee problems, the Decision says only, "There is no evidence that the charge nurses are empowered to adjust any ***formal*** employee grievances." (Dec. 19) (emphasis added). This superficial analysis reveals a fundamental misunderstanding of the role of the Employer's charge nurses.

At the hearing in this matter, the evidence clearly established that employee problems are regularly brought to and solved by charge nurses. (Tr. 117, 386-87). Theisen testified:

> Q. If a Nurse had a problem with an Aide or an Aide had a problem with a Nurse and the two of them couldn't work it out according to how they might otherwise deal with each other, where would they take that problem?
>
> A. To the Charge Nurse.
>
> Q. And what would the Charge Nurse do in that instance?
>
> A. They would try to facilitate resolution, whatever the problem was working with them to see if they can find out what was causing the problem and straighten it out. It might require reassignment of one of the Nursing Assistant[s], it might require just some direction, it might be just some problem solving on the spot.
>
> Q. Would that same scenario hold true if the Staff Nurse was having a problem with another Staff Nurse on a given shift?
>
> A. Yes.

(Tr. 117). When asked later by the hearing officer to give an example of how a charge nurse resolves disputes between employees, Theisen explained:

> If a nursing assistant complains that someone isn't doing what they're directing them to do, for instance, they could come up to the charge nurse and say, well, I told this nursing assistant to do this and she refused to do it and I tried talking to

her, would you go talk to her, and the charge nurse would get involved in it at that point. (Tr. 244-45).

The Decision of the Regional Director makes no mention of Employer Exhibit 8 (attached as Ex. E), the nursing Chain of Command Policy, which further describes the charge nurse's role in resolving problems on the unit. That document states as its objective "To provide a mechanism for the nursing staff to communicate and resolve issues and concerns," and sets forth a chain of command beginning with:

> Nursing staff member communicates verbally and/or in writing of a concern/issue to **charge nurse** and/or Clinical Manager/Clinical Supervisor.

(ER-8) (emphasis added). When UAW witness Nancy Coffee was asked about the policy, she admitted its application and testified:

> Q. If [a concern] is communicated to you, would you then do what is in the second step [of the policy], which is to take it to the next level?
>
> A. **If I couldn't resolve it, yes.**

(Tr. 588) (emphasis added).

That the charge nurses are the "first line" in the chain of command and, in that capacity, hear and act on employee concerns about co-workers, assignments and similar matters is precisely what is contemplated by "adjusting grievances" under the Act. The Regional Director's Decision improperly discredits substantial testimony on this point, choosing instead to conclude that Heritage's charge nurses do nothing more than relay staff complaints to clinical managers or assistant clinical managers. This factual conclusion is simply incorrect.

e. Other Considerations

(1) Charge Nurses are Provided Orientation and Training

The Decision of the Regional Director correctly recognizes that Heritage's charge nurses are provided orientation and training:

> RNs learn the responsibilities of a charge nurse through their education, and by initially working with a preceptor, or mentor. Preceptors will work along with the RNs as charge nurses until the RNs are able to perform the job on their own.

(Dec. 12). This statement fails to mention numerous critical facts.

In reality, each nurse hired in at Heritage goes through a general orientation, which includes specific training on functioning in the charge nurse position. (Tr. 234). After being oriented with respect to providing patient care, each nurse is "buddied" with a preceptor, who performs the charge nurse duties under the new nurse's observation. (Tr. 237-38). Gradually, the preceptor hands over charge nurse responsibilities to the new nurse, who would perform these duties under the preceptor's supervision. (Tr. 238). During this time, the clinical manager and assistant clinical managers observe the new nurse's performance in the charge nurse role and evaluate her ability to function in the position. (Tr. 238, 301). In determining whether a nurse is ready to function in the charge nurse role, the managers consider various factors, including "leadership qualities, "judgment," "problem-solving," and "communication." (Tr. 301). Clearly, it is only when a manager is comfortable with and confident in a nurse's ability to assume substantial responsibility that the nurse is allowed to rotate through the charge nurse position.

In addition to this hospital-wide charge nurse training, some units have put in place more formal programs and/or established written tools to evaluate an individual's ability to perform as a charge nurse. For example, Carol Carney, the Assistant Clinical Manager for Behavioral Health, testified that, on her unit, several training sessions were recently conducted to educate staff RNs on their duties and responsibilities when rotating through the charge position. (Tr. 298-99). Sue Caines, the clinical manager of Med/Surg East and Med/Surg West, testified that her predecessor utilized written documents, entitled "Checklist for Charge Nurse Orientation," to assess her nurses' ability to perform in the charge nurse role. (Tr. 396-97, ER-14) (attached as

Ex. F). These checklists were completed for most of the RNs currently working under Caines on these two units and remain in their files to this day. (Tr. 397-98, ER-14).

(2) Staff-to-Supervisor Ratios

The Decision of the Regional Director also dismisses out of hand the Employer's ratio argument, without so much as a mention of the data presented. ER-9 shows the actual staffing at Heritage from Sunday, November 18, 2001 through Saturday, December 8, 2001 (attached as Ex. G). These days were selected in order to provide an accurate sample of the staff to supervisor ratio, on all three shifts, given the daily fluctuations in these numbers. For each day, each shift is shown with an indication of the number of clinical supervisors, clinical managers, and assistant clinical managers on duty. (Tr. 120). Thus, this document reflects what the staff to supervisor ratio would be if charge nurses were not supervisors.

Upon review of ER-9, one cannot help but question the Regional Director's summary rejection of this evidence. As set forth below, if Heritage's charge nurses are not supervisors, the staff to supervisor ratio varies as follows for each shift:

Ratio of Staff to Supervisors

	High	Low
Day Shift	80:1	10:1
Afternoon Shift	86:1	19:1
Midnight Shift	58:1	26:1

In addition to the sheer absurdity of these ratios, there are other factors to consider:

- The Regional Director acknowledged that the clinical managers and assistant clinical managers on the day shift are not doing any day-to-day supervision of the nursing units. (Dec. 6-7).

- Only one clinical supervisor (house supervisor) is working on each off shift, and that individual is responsible for the entire hospital, not just the nursing areas. (Dec. 6). This involves overseeing all aspects of the hospital, including staffing, housekeeping, and maintenance, as well as nursing areas. (Dec. 6).

The evidence regarding the ratio of staff to supervisors in the instant case, in and of itself, is sufficiently compelling to support a finding that the charge nurses are supervisors under the Act. If the charge nurses are not supervisors, the staff to supervisor ratio at Heritage would range from 10:1 to an incredible 86:1. Additionally, these figures include Heritage's clinical supervisor, who is responsible for all areas of the hospital – both nursing and non-nursing – and Heritage's clinical managers and assistant clinical managers who manage their areas and have no role in the day-to-day supervision of unit personnel. More so than in a factory, or even in other health care institutions (i.e., nursing homes), it is simply *unconscionable* to believe that the patient care areas of this acute care hospital are essentially unsupervised on the afternoon and midnight shifts and supervised at incredibly unworkable ratios even on the day shift.[6]

(3) Permanent Charge Nurses vs. Rotating Charge Nurses

Although the Decision of the Regional Director correctly recognizes that Heritage utilizes both permanent and rotating charge nurses, it omits certain crucial facts about the dual nature of this position. (Dec. 12). Neither the duties nor the authority of a charge nurse differ by virtue of the fact that she is a permanent charge rather than a rotating charge. (Dec. 12). In fact, the Employer and the Union stipulated that charge nurses throughout Heritage – both permanent and rotating – are vested with the same authority. (Dec. 12).

The Decision of the Regional Director correctly describes a permanent charge nurse as an RN who functions as a charge nurse every time she works. (Dec. 12). Not every unit has permanent charge nurses, and even those units that do have permanent charges do not have one

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[6]Rather than address the statistical evidence presented at the hearing, the Regional Director says only, ". . . if all staff nurses are found to be supervisors, the ratio of nursing supervisors to nursing staff would be one supervisor for less than every two employees." (Dec. at 20). This statement is simply incorrect. The Employer's staff nurses are "supervisors" when they function in the charge nurse role. In that role, they are supervising not only the lesser-skilled unit employees referenced in the Regional Director's ratio calculation but also the other registered nurses on the unit.

on every shift. (Dec. 12). In fact, the Decision recognizes that there are only eleven (11) permanent charge nurses at Heritage. (Dec. 12). The Decision further recognizes that, "Where there is a permanent charge on a particular shift, the rotating charges on that shift take turns acting as a charge nurse on the days when the permanent charge is not working." (Dec. 12). What the Decision fails to mention, however, is that permanent charge nurses work only ten days in a fourteen-day pay period, leaving four days every two weeks when the charge position is filled by another staff RN on a rotating basis. (Tr. 152, 156).[7]

B. A Substantial Question of Law and Policy Is Raised Because Of the Departure from Officially Reported Board Precedent

Section 2(11) of the National Labor Relations Act defines "supervisor" as:

> . . . any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of merely routine or clerical nature, but requires the use of independent judgment.

This section is to be read in the disjunctive, which means that if any one of the indicia listed above is found to exist with respect to Heritage's charge nurses, they are supervisors under the Act. See NLRB v. Yeshiva University, 444 U.S. 672 (1980); Healthcare & Retirement Corp. v. NLRB, 987 F.2d 1256 (6th Cir. 1993), aff'd 511 U.S. 571 (1994).

An employee is a supervisor if she "(1) has the authority to engage in one of the activities enumerated in §2(11), (2) uses independent judgment in that activity, and (3) does so in the interest of the employer." Integrated Health Servs. of Michigan at Riverbend v. NLRB, 191 F.3d

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[7]The Decision also acknowledges that, although virtually all of Heritage's RNs rotate through charge, there are a few RNs who do not for one reason or another. (Dec. 12). Most nurses who do not rotate through charge are relatively new hires who have not yet demonstrated the ability to shoulder the additional responsibilities of the charge nurse position. (Dec. 12).

703, 707 (6th Cir. 1999) (internal citations omitted). Each of these conditions is satisfied on the record herein:

1. Section 2(11) Functions

As set forth above, the record evidence in this case clearly establishes the supervisory status of Heritage's charge nurses by virtue of their authority to assign, adjust grievances, and responsibly direct. Any one of these indicia, standing alone, is sufficient to confer supervisory status on the charge nurses. See Yeshiva University, supra; Healthcare & Retirement Corp., supra. Accordingly, by holding that the Employer's charge nurses are not supervisors within the meaning of the Act, the Decision of the Regional Director clearly runs afoul of Section 2(11) by departing from officially reported Board precedent holding that individuals possessing such authority are statutory supervisors and, therefore, excluded from the coverage of the Act.

2. "In the Interest of the Employer"

Prior to the Supreme Court's 1994 decision in NLRB v. Healthcare & Retirement Corp., 511 U.S. 571 (1994), the Board improperly applied a unique test when considering the supervisory status of charge nurses. In Healthcare & Retirement Corp., the Supreme Court held that the Board's long-applied approach to nursing cases was inconsistent with the ordinary meaning of "in the interest of the employer," as patient care *is the interest* (business) of health care institutions. Accordingly, a nurse who exercises any of the aforementioned indicia in furtherance of patient care is no less a supervisor under the Act.

3. Independent Judgment

The Union argued, and the Decision of the Regional Director concluded, that the assignment and direction of staff by Heritage's charge nurses is "merely routine" and thus fails to evidence sufficient "independent judgment" to confer supervisory status. (Dec. 19-20). The

Regional Director reached this conclusion despite a series of Sixth Circuit cases, culminating in the United States Supreme Court's recent affirmation of the Sixth Circuit's decision in Kentucky River Community Care v. NLRB, 193 F.3d 444 (6th Cir. 2000), which leave **no question** that Heritage's charge nurses are supervisors under the Act as a result of their assignment and responsible direction of staff.

The Sixth Circuit has repeatedly and adamantly held that there is nothing "routine" about directing others in the care of patients. See, e.g., Integrated Health Servs. v. NLRB, 191 F.3d 703, 711 (6th Cir. 1999); Grancare, Inc. v. NLRB, 137 F.3d 372, 375-76 (6th Cir. 1998). Moreover, the Sixth Circuit has regularly held that **the authority to assign and reassign staff in the care of patients is unquestionably indicative of supervisory authority** to "assign" and "responsibly to direct." See Caremore, Inc. v. NLRB, 129 F.3d 365, 369 (6th Cir. 1997). See also Beverly Health & Rehab. Servs. v. NLRB, Nos. 98-5160, 98-5259, 1999 WL 282695 (unpublished) (6th Cir., April 28, 1999) (providing direction to staff regarding patient care and moving staff between wings of facility "constitutes the authority 'responsibly to direct'" pursuant to §2(11) of the Act).

The Sixth Circuit has long rejected the Board's conclusions that supervisory duties do not establish the supervisory status of nurses because such duties flow from the nurses' professional "knowledge and training" and thus are "essentially routine in nature, and not requiring the exercise of independent judgment." Integrated Health Servs., 191 F.3d at 711. Rather, that Court has held that it is "**perfectly obvious** that the kind of judgment exercised by registered nurses in directing nurse's aides in the care of patients occupying skilled and intermediate care beds in a nursing home is not 'merely routine.'" Id. (emphasis added).

The Supreme Court's recent holding in NLRB v. Kentucky River Community Care, 121 S. Ct 1861, 1867 (2001), affirmed the Sixth Circuit's long-held position that independent judgment is no less independent where it is exercised by professionals such as charge nurses:

> The only basis asserted by the Board, before the Court of Appeals and here, for rejecting respondent's proof of supervisory status with respect to directing patient care was the Board's interpretation of the second part of the test – to wit, that employees do use 'independent judgment' when they exercise 'ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards.' The Court of Appeals rejected that interpretation, and so do we.

The record in this case is uncontested that the Heritage charge nurses are responsible for assigning, directing and reassigning other RNs, LPNs, nursing assistants, mental health workers, and other nursing unit staff in the patient care units on every shift. The clear facts in this case, when viewed in light of the Supreme Court's recent holding in Kentucky River, and the considerable and unambiguous precedent of the Sixth Circuit, lead to the inescapable conclusion that Heritage's charge nurses assign and responsibly direct with independent judgment and are supervisors under the Act. See Kentucky River, supra; Integrated Health Servs., supra; Mid-America Care Foundation v. NLRB, 148 F.3d 638 (6th Cir. 1998); Grancare, supra; Caremore, supra; Manor West, Inc. v. NLRB, 60 F.3d 1195 (6th Cir. 1995); Healthcare & Retirement Corp., 987 F.2d 1256 (6th Cir. 1993); Beverly California Corp. v. NLRB, 970 F.2d 1548 (6th Cir. 1992).

C. There are Compelling Reasons to Reconsider/Clarify Important Board Policy

The Regional Director's determination that the Employer's charge nurses are not statutory supervisors illustrates the need for the Board to reconsider and clarify the standards applicable to such cases in the wake of Kentucky River.

On May 29, 2001, the Supreme Court issued its decision in Kentucky River, rejecting the Board's interpretation of the "independent judgment" prong of the test for supervisory status, i.e.,

that registered nurses do not exercise "independent judgment" when using "ordinary professional or technical judgment" in directing less-skilled employees to deliver services in accordance with employer-specified standards. Kentucky River, 121 S. Ct. at 1863. Following Kentucky River, two ways have been posited by which charge nurses may be denied supervisory status, both of which were employed by the Regional Director in the instant case:

(1) In Kentucky River, the court held that the term "independent judgment" is "ambiguous with respect to the *degree* of discretion required for supervisory status." Relying on this language,[8] the Regional Director concluded that any judgment used by the Employer's charge nurses in assigning and directing staff is circumscribed by the Hospital's "operating regulations," rendering it insufficient to confer supervisory status. (Dec. 20).

(2) The Court also left open the question of the interpretation of "responsible direction" under Section 2(11), which the Board previously used to distinguish between "employees who direct the manner of others' performance of discrete tasks from employees who direct other employees." Majestic Star Casino, 335 NLRB No. 36 (August 27, 2001), quoting Kentucky River, 121 S. Ct. at 1871. Again, not surprisingly, the Regional Director seized this opening and concluded that the "limited authority of RNs to assign discrete tasks to less skilled employees" does not establish supervisory status under the Act." (Dec. 19).

The Regional Director's reliance on these two points is at best unpersuasive.

1. "Independent Judgment" in Light of Employer Rules and Policies

In the instant case, the Regional Director concluded that, although the Employer's charge nurses may assign and responsibly direct nursing staff in the performance of their duties, the charge nurses do so in keeping with "the superior's standing orders and the employer's operating regulations." (Dec. 20). In essence, the Regional Director believes that the existence of the Employer's "Assignment of Nursing Personnel" policy (ER-7) (attached as Ex. D) precludes a finding that Heritage's charge nurses exercise independent judgment in assigning and responsibly directing nursing staff. With all due respect, this is ludicrous.

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[8]See Beverly Health & Rehabilitation Servs., 335 NLRB No. 54 (Aug. 27, 2001).

First and foremost, the policy at issue is nothing more than an articulation of the varied factors to be considered by charge nurses in deciding which patients should be assigned to which staff members. (ER-7). In fact, the "policy" does little more than remind charge nurses to consider factors such as acuity, staff abilities, staff experience, and personality when making out an assignment. Even with the existence of this policy, the fact remains that, on each and every shift, a charge nurse must use independent judgment in **analyzing and applying these factors to meet the changing needs of her patients and the changing abilities of her staff.**

Moreover, in the brief time since the decision in Kentucky River was issued, courts have already expressed disagreement with the Board's position that the existence of applicable rules or regulations precludes a finding of "independent judgment." In NLRB v. Quinnipiac College, 256 F.3d 68, 75-76 (2d Cir. 2001), the court rejected the Board's determination that the employer's shift supervisors did not use independent judgment in assigning lower-level employees simply because the employer maintained "policies and procedures" governing this function. According to that court, "**the existence of governing policies and procedures and the exercise of independent judgment are not mutually exclusive.**" Id. at 75-76 (emphasis added). Thus, the Regional Director's Decision is doubly wrong: there are no Employer policies, orders, or regulations that restrict the judgment used by charge nurses in assigning and responsibly directing less-skilled employees and, even if there were, such policies do not preclude a finding that the charge nurses use independent judgment.

2. *Assigning Tasks vs. Assigning Employees*

The Regional Director's attempt to deny supervisory status to the Employer's charge nurses by concluding that they "assign discrete tasks" to employees, rather than "assigning employees" is a "red herring." In his opinion, the Regional Director cites numerous examples of

tasks assigned by ***staff RNs***, not ***charge nurses***, to lesser-skilled employees on the nursing units. (Dec. 11). From this, the Regional Director concludes that, "The limited authority of RNs to assign discrete tasks to less skilled employees . . . does not require the use of independent judgment in the direction of other employees." (Dec. 19). This conclusion is not only legally questionable, but also misses the mark completely. It is not the Employer's contention that every RN is exercising supervisory authority at all times, **but, rather, that when in charge, whether as a rotating or permanent charge, the *charge nurses* are most certainly using independent judgment in the exercise of their supervisory authority to assign and direct.** Moreover, these charge nurses are not only making assignments for and issuing direction to the "less-skilled" members of the nursing units but also the staff RNs.

II. THE REGIONAL DIRECTOR INCORRECTLY CONCLUDED THAT A MULTI-SITE UNIT CONSISTING OF OHI'S FOUR ACUTE CARE HOSPITALS IS NOT THE APPROPRIATE UNIT

A. Decisions Respecting Substantial Factual Issues Are Clearly Erroneous and Prejudicially Affect the Rights of the Employer

The Decision of the Regional Director misapprehends the facts presented on the multi-site issue. In addition, the Decision fails to reflect consideration of numerous facts demonstrating that a system-wide bargaining unit is appropriate. These errors and omissions prejudicially affect the rights of the Employer and necessitate review and reversal of the affected portions of the Decision.

1. Correct Determinations of Fact

The Regional Director correctly found that OHI's four acute care hospitals are located in the southwestern suburbs of Detroit, the greatest distance between any two facilities being 22 miles. There is a single board of directors and management structure overseeing the operations of all four of OHI's acute care facilities. (Dec. 3).

OHI's President and Chief Executive Officer is Gerald D. Fitzgerald. (Dec. 3). Directly under Mr. Fitzgerald is Joseph Diederich, OHI's Chief Operating Officer, who is responsible for care delivery across the entire OHI system, including the four acute care hospitals at issue. (Dec. 3). OHI has a centrally located Human Resources Department, headed by John Furman (the Executive Vice-President of Human Resources) who reports directly to Mr. Fitzgerald. (Dec. 4). Along with Furman, Ed Frysinger (the Corporate Director of Employee and Labor Relations and Staffing), Dan Smorynzki (the Corporate Director of Compensation and Benefits), and Verna Bastedo ("Bastedo") (the Corporate Director of Employee and Labor Relations) share responsibility for developing and implementing **all** human resources policies for employees across the OHI system. (Dec. 4).

The Regional Director also properly found that OHI maintains a single employee handbook covering employees at all four acute care hospitals. (Dec. 4). This handbook governs numerous employment matters, including attendance, leave, transfers, and benefits. (Dec. 4). In addition, the corporate Human Resources Department has developed and implemented standardized personnel forms applicable to "virtually all events and actions," including reimbursable mileage, applications for employment, new hire information, tuition reimbursement, corrective action, benefit changes, time-off requests, and alternate scheduling agreements. (Dec. 4; Annap. ER-3, 5, 6, 18, 22, 30, 36-39, 42). The use of a single employee handbook and standard, system-wide forms ensures that employees throughout the OHI system are treated in the same manner, regardless of the facility at which an employee regularly works.

2. *Omitted Determinations of Fact*

The Decision of the Regional Director is remarkable not so much in that its conclusions are factually inaccurate (although some certainly are) but in its consistent failure to take notice of material facts established throughout the four days of hearing on the multi-site issue. Specifically, the Decision omits numerous crucial facts in the following areas: (1) human resources policies and procedures; (2) compensation and benefits; (3) the centralization of nursing administration; (4) the consolidation of services; (5) the centralization of corporate operations; (6) employee transfers; and (7) prior bargaining history. Moreover, despite the fact that a multi-facility bargaining unit of registered nurses at the Employer's acute care hospitals was rejected in 1994 for certain very specific reasons, the Decision of the Regional Director almost willfully refuses to note the obvious distinctions between then and now.

a. System-Wide Human Resources Policies and Procedures

The Decision of the Regional Director omits substantial testimony as to the extent, impact, and significance of OHI's common Human Resources Policies and Procedures Manual, which uniformly governs the terms and conditions of employment for all of OHI's non-union employees, including registered nurses. (Annap. Tr. 202). In his Decision, the Regional Director says only that OHI's corporate Human Resources Department "has promulgated uniform attendance, leave, and transfer policies and procedures." (Dec. 4). In fact, the manual contains numerous system-wide policies covering topics such as vacation requests, sick days, rest periods, breaks, rehire, hours of work and scheduling, reductions in force, dress code, professional society participation, worker's compensation, and safety. (Annap. Tr. 202). In contrast to the uniform, system-wide human resources policies in effect for all four hospitals, there are no "local" or site-specific human resources policies at any of these facilities. (Annap. Tr. 123). Each of the four

acute care hospitals utilizes the same Human Resources Policies and Procedures Manual, and no individual at any of these hospitals has the authority to modify or deviate from these policies without the approval of the corporate Human Resources Department. (Annap. Tr. 204).

In addition to its material omissions with respect to OHI's Human Resources Policies and Procedures Manual, the Decision of the Regional Director is also deficient in its consideration of OHI's employee handbook. Aside from acknowledging that OHI maintains a single employee handbook covering employees at all four acute care hospitals (Dec. 4), the Decision ignores the significance of the handbook.

For example, the Decision of the Regional Director recognizes that the employee handbook contains OHI's problem resolution procedure, a five-step process culminating in impartial arbitration for issues involving suspension or termination. (Dec. 6). The Regional Director also correctly describes the problem resolution procedure, which is as follows:

- Steps 1 and 2 of the process involve informal meetings between the employee and her immediate supervisor and department head respectively. (Dec. 6).
- At Step 3, the employee meets with a site human resources representative (a member of the corporate Human Resources Department who may be stationed at the employee's site or at another one of the acute care facilities). (Dec. 6).
- At Step 4, either Bastedo or Frysinger (both of whom are corporate Directors of Employee and Labor Relations) become involved in attempting to resolve the problem. (Dec. 6).

However, in focusing on the ability of individual managers and department heads to resolve problems at Step 1 or Step 2 of the problem resolution procedure, the Regional Director misses the point: ***even in resolving problems informally, these individuals are bound by (and may not deviate from) OHI's system-wide policies and procedures***. (Annap. Tr. 112-15).

The Decision of the Regional Director also misapprehends the role of individual supervisors in implementing the progressive discipline system set forth in OHI's handbook.

Although the Decision correctly recognizes (1) that all employees covered by OHI's handbook are subject to the same work rules and progressive discipline system; and (2) that all discipline is recorded on standardized corrective action forms and sent to the Human Resources Department (Dec. 5-6), the Decision ignores the critical fact that any major disciplinary action (including suspension or discharge) requires the approval of ***corporate human resources personnel.*** Moreover, the Decision of the Regional Director omits two very important facts:

- In issuing verbal or written warnings, individual supervisors must apply the work rules as written and cannot modify these rules, reclassify the infraction, or impose a greater or lesser penalty. (Annap. Tr. 235).
- In practice, individual supervisors rarely impose <u>any</u> discipline without consulting with a member of the corporate Human Resources Department in order to ensure that the discipline to be imposed is consistent with the procedure set forth in the employee handbook. (Annap. Tr. 233).

Thus, the Regional Director exaggerates the role of individual supervisors in imposing discipline, while ignoring the critical requirement of corporate human resources approval.

b. Compensation and Benefits

The Regional Director correctly recognizes that OHI's corporate Human Resources Department – more specifically its Total Compensation Department – formulates and revises system-wide wage ranges for employees in every job classification across the OHI system, including registered nurses. (Dec. 4). This uniform system encompasses minimum and maximum starting wages for each job description and allows for the consideration of years of experience in accordance with a centrally determined grid in determining an individual nurse's starting pay. (Dec. 8). These wage rates apply across the system, and individual managers may not vary from the organizational guidelines. (Dec. 8).

What the Regional Director fails to recognize, however, is that these facts apply equally to *adjustments* to the pay rates of registered nurses. The Total Compensation Department is

responsible for examining relevant labor markets to determine whether adjustments to the existing pay structure are warranted. (Annap. Tr. 78-79). Moreover, the Total Compensation Department keeps tabs on the wage differentials between various job classifications; if the difference becomes too small or great, this group develops system-wide equity adjustments. (Annap. Tr. 80). Again, individual site personnel have no authority to adjust a nurse's salary, even if he or she feels that the market demands such action. (Annap. Tr. 81).

In addition to its omissions regarding OHI's system-wide wage structure, the Regional Director also omits substantial unrebutted testimony as to other ways in which OHI has standardized the compensation provided to employees. For example:

- The Total Compensation Department has implemented a system-wide policy governing the payment of holiday pay. (Annap. Tr. 231).
- Overtime pay for registered nurses is calculated on the same "8/80" basis throughout the entire OHI system. (Annap. Tr. 231).
- Alternate scheduling agreements, which provide registered nurses the option of working non-traditional ten-or twelve-hour shifts, are standard throughout the OHI system and are used by nurses at all four acute care hospitals. (Annap. Tr. 230; Annap. ER-42). Moreover, individual managers have no authority to establish different alternate schedules. (Annap. Tr. 332).
- OHI has implemented a system-wide policy governing the procedures applicable to nurses working in the "flex pool" and the "system flex pool."[9] (Annap. ER-13). The wage rates paid to flex or system-flex nurses are the same across the system and are determined based on an individual nurse's ability to work multiple shifts and to work in one or more nursing units. (Annap. ER-13).

As it does with respect to compensation, the Decision of the Regional Director correctly recognizes that OHI's Total Compensation Department designs and implements system-wide fringe benefit packages for employees (including registered nurses) across the OHI system. (Dec.

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[9]The difference between a flex nurse and a system flex nurse revolves around where an individual nurse spends most of her time. For example, a flex nurse at Heritage would work at Heritage on a flex (or on-call) basis, while a system-flex nurse would work at any of the four acute care hospitals on an as-needed basis. (Annap. Tr. 200).

4). Again, however, the Decision omits substantial testimony as to the uniformity of the benefits received by OHI's registered nurses, including the following:

- Both full-time and part-time registered nurses at all four acute care hospitals receive the same health, dental and vision insurance, life insurance, short and long term disability, and retirement savings options. (Annap. ER-8, 12, 16, 17).

- None of the acute care hospitals has an on-site benefits administrator. (Annap. Tr. 131). Any questions or concerns about benefits must be directed to and addressed by members of the corporate Total Compensation Department. (Annap. Tr. 131).

Finally, although the Decision of the Regional Director mentions OHI's central Payroll Department (Dec. 4), it ignores the highly-centralized nature of OHI's payroll process:

- All four acute care hospitals have the same payroll period and payday, and each employee's paycheck is calculated centrally at OHI's administrative headquarters. (Annap. Tr. 220).

- Paychecks are issued not by each acute care hospital but by OHI and are signed by both the President and Chief Financial Officer of OHI. (Annap. Tr. 222).

- None of the four acute care hospitals has payroll capabilities, and there is no payroll representative at any of the facilities. (Annap. Tr. 225). If an employee at Heritage discovers a paycheck error, the Payroll Department would be contacted to investigate the issue and make any necessary correction. (Annap. Tr. 224).

c. Centralization of Nursing Administration

The Decision of the Regional Director also omits extensive evidence of the centralization of OHI's nursing operations, including the importance of both OHI's Acute Care Nursing Operations Council ("Nursing Operations Council") and OHI's use of "clinical pathways" in standardizing care across the system.

Although the Decision mentions the Nursing Operations Council in passing (giving it credit for developing nursing job descriptions and centralized staffing guidelines, for example), the Decision fails to recognize the critical role this body plays in formulating both administrative and clinical policies. The Nursing Operations Council, which is chaired by OHI's Chief Nursing

Officer, also includes the nursing site leaders for Heritage, Annapolis, Dearborn, and Seaway, as well as certain service line leaders, clinical managers, and nurse recruiters. (Annap. ER-45). The Nursing Operations Council is a true governing body that develops and implements a unified, thorough set of administrative policies and procedures, which apply to all OHI registered nurses. (Annap. Tr. 389-93). These policies and procedures are collected in the Nursing Administrative Policy and Procedure Manual, copies of which are located at each of the four acute care hospitals. (Annap. Tr. 395; Annap. P-13).

Through its various sub-committees, the Nursing Operations Council also establishes clinical policies and procedures applicable to nurses across the OHI system. (Annap. Tr. 389-93, 451-54). Each committee includes representatives from all four acute care hospitals and is responsible for developing system-wide clinical nursing policies and procedures.

Even more amazingly, the Decision of the Regional Director does not even mention OHI's clinical pathways, which were designed and implemented between 1995 and 1997 to standardize the care for individuals with particular diagnoses across the OHI system. (Annap. Tr. 461). Multi-disciplinary teams were formed to develop clinical pathways for different diagnoses, and each team consisted of clinicians from across the OHI system, including staff nurses from the various acute care facilities. (Annap. Tr. 462; see Annap. ER-55 through Annap. ER-61). The clinical pathways now in place essentially provide road maps for the care of individuals with certain diagnoses, thus standardizing patient care across the OHI system, a fact that the Regional Director ignores completely. (Annap. Tr. 462-69).

d. Consolidation of Services and Referral of Patients Among Acute Care Facilities

Although the Decision of the Regional Director correctly recognizes that OHI's four acute care hospitals each provide different combinations of services, the Decision makes no

mention of the concerted effort undertaken by OHI to coordinate the services offered at its various facilities. In fact, the record is replete with testimony as to the ways in which OHI has consolidated the provision of services and facilitated the transfer of patients between acute care hospitals for necessary services.

In January 1999, OHI ceased providing obstetrics services at Beyer Hospital.[10] (Annap. Tr. 433). Then, in October 2000, the obstetrics unit at Seaway was closed. (Annap. Tr. 435-36). Thus, while as recently as 1999 there were four facilities providing these services, there are now only two acute care hospitals – Dearborn and Annapolis – with obstetrics departments. (Annap. Tr. 433-35). A patient who presents at either Heritage or Seaway in need of obstetrics services will be referred and/or transferred to either Dearborn or Annapolis.

Similarly, in-patient mental health services recently have been consolidated at two of the four acute care hospitals (Dearborn and Heritage). (Annap. Tr. 488-90). Again, a patient who presents at either Annapolis or Seaway in need of in-patient mental health services will be referred and/or transferred to either Dearborn or Heritage for treatment. (Annap. Tr. 488-90).

Prior to 1999, pediatrics services were provided at Dearborn, Heritage, and Annapolis; due to a consolidation within the OHI system, these services are now provided only at Dearborn and Annapolis. (Annap. Tr. 492). Patients at Heritage or Seaway who need pediatric services are referred and/or transferred to Dearborn or Annapolis.

The Decision fails to mention that, in addition to consolidating the services described above, OHI has long provided numerous other services only at specific acute care facilities, rather than across the OHI system. For example:

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[10]Beyer Hospital, located in Ypsilanti, Michigan, was closed in April 2000 and, thus, is not included in the multi-facility unit now proposed by OHI.

- Dearborn is the only acute care hospital providing treatment for cancer. (Annap. Tr. 651). Specifically, within OHI's acute care system, radiation therapy, chemotherapy, and bone marrow transplants are performed only at Dearborn. (Annap. Tr. 652-58).

- Certain cardiac services, including cardiac surgery, electrophysiology, and interventional cardiology are performed only at Dearborn. (Annap. Tr. 658-66).

- Certain types of surgery are performed only at specific sites. For example, cardiac surgery, neurosurgery, pediatric surgery, and urogynecology surgery are performed only at Dearborn, while podiatric surgery is performed only at Annapolis. (Annap. Tr. 669-77). Moreover, cataract surgery is performed at Annapolis, Heritage, and Seaway but not at Dearborn. (Annap. Tr. 669-77).

- Heritage is the only acute care hospital with a Sleep Lab. (Annap. Tr. 678).

- Heritage also is the only acute care facility with a Pain Clinic, which provides services related to the diagnosis and treatment of chronic pain. (Annap. Tr. 682-84).

Thus, while the Decision of the Regional Director reflects some understanding of the fact that certain services are provided only at certain facilities within the OHI system, it omits extensive unrebutted testimony as to the consolidation of services and the transfer of patients within the OHI system, all of which is crucial to an assessment of OHI's functional integration.

e. Centralization of Corporate Operations

Despite extensive evidence of the steps taken by OHI to centralize its corporate (as well as medical and nursing) functions, the Decision of the Regional Director virtually ignores this indicia of functional integration. On this topic, the Decision of the Regional Director acknowledges only that (1) OHI has a single board of directors, President, and Chief Operating Officer who are responsible for the administration of all four acute care hospitals; (2) OHI supports its hospitals with centrally handled materials management, laundry, patient billing, medical transcription, accounting, payroll, marketing, public relations, human resources, and risk management services; and (3) certain basic foodstuffs are prepared at Dearborn and then delivered to the other acute care hospitals. (Dec. 3-4).

When compared to the vast amount of unrebutted evidence presented on this issue, the Decision of the Regional Director does not even scratch the surface of OHI's operational centralization. In addition to the Decision's observations on this issue, there is extensive record evidence as to the following:

- The receiving, distribution, and inventory of supplies are done on a system-wide basis. (Annap. Tr. 759).
- There is a central sterile supply and processing function, which is responsible for washing, sterilizing, and otherwise re-processing various surgical instruments for use at all four acute care facilities. (Annap. Tr. 759).
- The ordering and purchasing of various products – from food to forms to medical and surgical instruments – is done on a system-wide basis. (Annap. Tr. 763-66).
- OHI has implemented a "One Look, One Touch, One Feel" program which is designed to standardize the appearance of the various OHI facilities. (Annap. Tr. 778-81). To this end, OHI has adopted uniform standards with regard to carpets, interior finishes, and furniture. (Annap. Tr. 778-81; ER-72; ER-73).
- OHI has instituted a Clinical Products Committee, made up of individuals across the system, who review products (primarily medical and surgical items) that are being considered for use in the various OHI facilities. (Annap. Tr. 773-77). The Clinical Products Committee is made up of representatives of various departments and facilities across OHI, including nurse managers and staff nurses from all four acute care hospitals. (Annap. ER-70). The committee acts on a system-wide basis to develop specifications for products, contact potential vendors, establish clinical trials at various hospitals, review products using established criteria, and arrive at a consensus as to whether to purchase a product for use across the OHI system. (Annap. Tr. 773-77).

f. Transfer of Employees

In describing OHI's policy governing voluntary transfers of employees between acute care facilities, the Decision of the Regional Director omits several material facts. For example:

- In order to initiate a voluntary transfer, an employee must complete and submit to OHI's Human Resources Department a standard Transfer Request Form, which is used system-wide.[11] (Annap. ER-22).

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[11]On the Human Resources Change Form, which records internal job transfers, all four acute care hospitals are represented by one box, which is labeled "(OHI) Dearborn and Community Hospitals," indicating that a transfer between these hospitals is the equivalent of a transfer from department to

- Vacant registered nurse positions throughout the OHI system are posted simultaneously at all four acute care hospitals. (Annap. Tr. 149-51; Annap. ER-19).

- Employees at the facility where the job opening exists are not given priority over any other OHI employee. (Annap. Tr. 152).

- A nurse who transfers from one site to another retains her accumulated sick and vacation time. (Dec. 9). Moreover, a transferring nurse's seniority follows her to her new site for purposes of determining eligibility for service awards, vacation, sick time, and health benefits. (Annap. Tr. 152).

As to permanent transfers of employees, the Decision correctly states that, during the 14½ months preceding the hearing, 33 OHI nurses permanently transferred into or out of Annapolis from or to one of the other acute care facilities (Dearborn, Seaway, Heritage, or Beyer). (Dec. 9). Moreover, during this same period of time, approximately 80 OHI registered nurses were permanently transferred between and among Heritage, Beyer, Annapolis, Dearborn, and Seaway. (Dec. 9-10).

With respect to temporary transfers of registered nurses, the Decision of the Regional Director correctly recognizes that, during the five month period immediately preceding the hearing, there were approximately 70 nurses who were temporarily transferred between and among OHI's four acute care hospitals. (Dec. 10). However, the Decision attempts to minimize the significance of this interchange by ignoring evidence that the nurses who were temporarily transferred worked *thousands of hours* outside their home units during this five month period. (Annap. ER-25).

Finally, the Decision of the Regional Director also fails to mention OHI's system flex pool, a group of around 30 registered nurses who work at the various acute care hospitals on an as-needed basis, further illustrating the way in which registered nurses at one acute care hospital interact with their peers at other facilities. (Annap. Tr. 185-89).

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department within any one of these hospitals. (Annap. ER-36).

g. Prior Bargaining History

Despite correctly recognizing that there is no history of collective bargaining among the registered nurses at OHI's four acute care hospitals (Dec. 2), the Decision omits certain material facts pertaining to OHI's prior bargaining history. In 1985, prior to the time that OHI acquired and began operating the hospitals now at issue, a consent election was conducted involving registered nurses at Heritage, Annapolis, Beyer, Seaway, and Outer Drive Hospitals.[12] This system-wide election, which clearly establishes that even as far back as 1985 OHI's acute care hospitals were considered part of a single system, was not mentioned in the Decision.

The Decision also correctly points out that the service and maintenance employees at Annapolis, Heritage, and Seaway Hospitals are all represented by a single union and are all covered by a single collective bargaining agreement. (Dec. 2-3). This collective bargaining relationship dates back to 1967. (Dec. 2-3).

h. Comparison to the Region's 1994 Decision

Despite the fact that, in formulating his questions and in considering the evidence, the hearing officer in Case No. 7-RC-21970 gave substantial consideration to the factors relied on by the Region in its 1994 Decision, the Decision is conspicuously silent on this issue. However, a brief comparison of the facts relied on by the Region in 1994 with the facts as they exist now clearly demonstrates that much has changed since 1994. For example:

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[12]At that time, the hospitals were owned by the People's Community Hospital Authority, a public entity, and the election was conducted by the Michigan Employment Relations Commission, which applies similar unit determination criteria as the NLRB. See Ionia County, 1984 MERC Lab. Op. 497 (1984). Outer Drive Hospital was closed subsequent to the election.

Facts at Time of 1994 Decision	Facts Now
No single Board of Directors. (Annap. Tr. 25).	Single Board of Directors oversees all four acute care hospitals. (Dec. 3).
On-site human resources representatives focused almost exclusively on the site at which they were stationed. (Annap. Tr. 59).	On-site human resources representatives perform tasks at all four acute care hospitals. (Dec. 5).
No common employee handbook. (Annap. Tr. 86).	Common employee handbook covering all four acute care hospitals. (Dec. 4).
When filling vacancies, preference given to employees at facility where the vacancy existed. (Ex. B at 7).	Vacancies filled with most qualified candidate. Preference not given to candidates working at facility where vacancy exists. (Annap. Tr. 152).
Hospitals maintained separate seniority lists, and there were no bumping rights between facilities. (Ex. B at 7).	During a reduction-in-force, service line employees may bump less senior employees in the same service line, even if the less senior employee works at a different hospital. (Dec. 9).
Different starting wage rates in place across the system for individuals in the same job classification. (Annap. Tr. 82).	System-wide pay structure in place, and local site personnel may not deviate from the organizational wage rates. (Dec. 4).
Overtime pay was calculated on an 8/80 basis for nurses at Heritage, while Dearborn's nurses were paid overtime for hours in excess of forty per week. (Annap. Tr. 231).	Registered nurses at all four acute care hospitals are paid overtime on an 8/80 basis. (Annap. Tr. 231).
No central payroll department. (Annap. Tr. 225).	There is a central Payroll Department, servicing the entire system. (Dec. 4).
Non-registered-nurse recruitment conducted on site-by-site basis. (Annap. Tr. 65-66).	All recruiting – registered nurses and otherwise – conducted on system-wide basis. (Dec. 5).

Critically, in the 1994 Decision, the Region noted that there was very little functional integration throughout the OHI system and appeared to base its decision, in large part, on the absence of such integration. Specifically, the Region said:

> While there is some limited integration of medical services between the OUHI hospitals, **the fact remains that the overwhelming degree of the medical care provided by Heritage and by each of the other four OUHI hospitals is identical, but not confined to each respective hospital's premises.** Only in rare instances are patients transferred between hospitals.
>
> * * *
>
> Patient care proceeds for the most part independently at each hospital and day-to-day personnel matters as they most directly affect the RNs are administered within the separate hospitals.

(Ex. B at 6-7) (emphasis added). As described above, since the time of the 1994 Decision, tremendous changes have been made throughout the OHI system in an effort to streamline and standardize patient care across the four acute care hospitals.

Also, the degree of employee interchange between the acute care facilities has increased significantly since 1994. As the Region pointed out in the 1994 Decision, very few transfers (temporary or permanent) were occurring between OHI's acute care facilities at that time. (Ex. B at 4-5). Specifically, the Region found:

> The record indicates that since 1989 there have been 34 RNs from an RN staff of about 900 who have permanently transferred from one OUHI hospital to another OUHI hospital.
>
> * * *
>
> The record further establishes that it is rare for RNs to be transferred temporarily from one hospital to another. In fact, this has only happened twice in the last three years and only on a voluntary basis during emergencies.

(Ex. B). While between 1989 and 1994 there were only 34 registered nurses who were permanently transferred between acute care facilities, **there were approximately 80 such transfers between January 2000 and March 2001**. (Dec. 9-10). Similarly, between 1991 and 1994, there were only two temporary transfers of employees between acute care hospitals, **while there were approximately 70 such transfers a five-month period spanning late 2000 and early 2001**. (Dec. 10). Thus, the record clearly establishes that both temporary and permanent transfers of registered nurses between and among OHI's acute care hospitals are far more common now than they were in 1994.

3. Incorrect Determinations of Fact

In addition to the material factual omissions it contains, the Decision of the Regional Director makes incorrect factual determinations in three substantial areas: recruiting and hiring, the nursing reporting structure, and the impact of service lines on OHI's functional integration.

a. Recruiting and Hiring

The Decision correctly recognizes that OHI's corporate office of staffing coordinates the recruiting of registered nurses across the entire OHI system. (Dec. 5). The Decision also correctly states that all job openings are advertised on a system-wide basis. (Dec. 5). However, the Decision is less than accurate in describing OHI's application process.

After acknowledging that all applicants for jobs within the OHI system complete the same standard application form (Dec. 5), the Decision simply ignores the uniform manner in which these job applications are processed. Specifically, once a job application is received anywhere in the OHI system (including at any of the four acute care hospitals), the application is forwarded to OHI's administrative headquarters, where it is entered into the People Soft system (OHI's system-wide human resources database). (Annap. Tr. 67) From there, each applicant is randomly assigned a People Soft ID number, which allows for central control over the status of the application. (Annap. Tr. 67).

Second, the Decision of the Regional Director correctly recognizes that, after a nurse's application is entered into the People Soft system, a corporate nurse recruiter conducts the initial screening process, which involves making a preliminary inquiry into the candidate's minimum qualifications and requesting a background check. (Dec. 5). However, in contrast to the unrebutted testimony, the Decision of the Regional Director fails to conclude that if, during this initial process, the nurse recruiter views the applicant as unsuitable for employment at OHI for any reason, the applicant receives no further consideration. (Annap. Tr. 72-74). This is true regardless of whether a department head at a particular hospital may have been happy to hire the candidate. (Annap. Tr. 72-74).

The Decision further minimizes the crucial role played by OHI's corporate nurse recruiters, saying that "the recruiter does not participate in the clinical manager's interview regarding specific job qualifications." (Dec. 5). In truth, the corporate nurse recruiter is responsible for evaluating the candidate's areas of interest to determine potential matches with openings across the system. (Annap. Tr. 71). If the recruiter believes that the applicant can fill a need within the OHI system, the recruiter interviews the applicant with respect to all employment-related criteria, i.e., compatibility, motivation, etc. (Annap. Tr. 72-73). If the recruiter is not satisfied with the applicant after the initial interview, the applicant is disqualified and the process goes no further. (Annap. Tr. 72-73).

It is only after this initial interview, if the **recruiter** is still satisfied that the applicant meets OHI's standards, that all data on the employment application is verified and arrangements are made for an interview with the nurse manager for the area in which the nurse recruiter believes the applicant may be able to fill an opening. (Dec. 5). The nurse manager interviews the candidate solely to assess the candidate's experience level and clinical competence. (Dec. 5).

Contrary to the Regional Director's findings, the clinical manager does not merely select the most qualified candidate and inform the nurse recruiter of the decision." (Dec. 5). In reality, after both the recruiter and the nurse manager interview the candidate, they meet to discuss the candidate. (Annap. Tr. 74). If the recruiter approves of the candidate, and the nurse manager verifies the candidate's clinical competency, the **recruiter** extends the candidate an offer of employment. If the nurse manager and the recruiter disagree as to the candidate's suitability, the decision is pushed up to each individual's supervisor. (Annap. Tr. 303). Clearly, an individual manager does not have the authority to unilaterally overrule a recruiter's hiring recommendation, and the record contains ample evidence of instances where an applicant was hired despite the fact

that the interviewing nurse manager believed the candidate unsuitable for employment. (Annap. Tr. 340-48). Thus, throughout the entire recruiting, application, and hiring process, the nurse recruiters (who are corporate employees with system-wide responsibility) retain significant responsibility for making critical decisions.

b. Use of Service Lines to Standardize Care Across the OHI System

In the last few years, OHI has created "service lines" in order to coordinate the delivery of patient care across the entire OHI system. (Annap. Tr. 650). The term "service line" was defined succinctly by Mark Anthony, OHI's Administrator of Clinical Services, who referred to a service line as an "organizational structure that coordinates the delivery of clinical services across the system within a clinical specialty." (Annap. Tr. 650).

The Regional Director's Decision reflects a lack of understanding of the service lines:

> Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines."

(Dec. 7 at footnote 8). In fact, the testimony was clear that there are numerous service lines across the OHI system, including cardiology, oncology, behavioral health, laboratory, emergency services, surgical services (including anesthesia, operative, and recovery services), and women's and children's services. (Annap. Tr. 651). Thus, with the advent of service lines, OHI has taken a significant step toward the further integration of its four acute care hospitals.

With respect to the reporting structure of registered nurses working within service lines, the Decision of the Regional Director simply mischaracterizes the record. Despite extensive testimony to the contrary, the Decision states:

> All registered nurses at the hospitals report directly to on-site nursing supervisors . . . . [T]he development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader.

(Dec. 7). In reality, registered nurses working in service lines at Heritage do not report to the nursing site leader, as would a non-service-line nurse. (Annap. Tr. 663). Rather, registered nurses in service lines report up to a service line leader, who is responsible for all nurses working in that service line across the OHI system. Thus, the substantial number of registered nurses at Heritage who work in service lines report up through a corporate chain of command and are not supervised by Brenda Theisen, Heritage's Nursing Site Leader.

B. A Substantial Question of Law and Policy is Raised Because of the Departure from Officially Reported Board Precedent

1. General Standards

Section 9(a) of the National Labor Relations Act ("Act") provides that, to gain status as an exclusive representative for purposes of collective bargaining, a labor organization must be "designed or selected . . . by the majority of the employees in a unit **appropriate** for such purposes . . . ." 29 U.S.C. §159 (emphasis added).

As the Regional Director correctly recognized, when considering the appropriateness of a unit confined to one facility of an employer engaged in multi-facility operations, the NLRB relies upon the "single-facility presumption."[13] (Dec. 15). That presumption, however, may be rebutted by demonstrating "functional integration so substantial as to negate the separate identity of the single-facility unit." Heritage Park Health Care Center, 324 NLRB 447 (1997). Under Board law, where such integration occurs, "the multi-facility unit is the appropriate unit even though another unit, if requested, might also be appropriate." Dixie Belle Mills, Inc., 139 NLRB No. 61 (1962); see also Samaritan Health Services, Inc., 238 NLRB 629 (1978).

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[13]Although both Board members and courts have expressed concern that the application of the single-facility presumption in the health care industry will result in unwarranted unit fragmentation, the Board has declined to except the health care industry from the single-facility presumption. See Manor Health Care Corp., 285 NLRB 224 (1987).

In determining whether the single-facility presumption has been rebutted in a given case, the Board examines the following so-called "traditional factors":

(1) central control over daily operations and labor relations, including the extent of local autonomy over these functions ("administrative centralization");

(2) functional integration of the employer, including the similarity of employee skills, functions, and working conditions ("functional integration");

(3) degree of employee interchange;

(4) geographic proximity; and

(5) prior bargaining history.

See, e.g., Heritage Park Health Care Center, 324 NLRB 447 (1997); D & L Transportation, Inc., 324 NLRB 160 (1997); West Jersey Health System, 293 NLRB 749 (1989). In general, in order to rebut the single-facility presumption, both administrative centralization and functional integration must be demonstrated. See O'Brien Memorial, Inc., 308 NLRB No. 79 (1992).

2. Relevant Board Law

In West Jersey Health System, 293 NLRB 749 (1989), the Board held that a multi-facility bargaining unit was proper where the employer operated four facilities within a twenty-mile radius. In its decision, the Board considered the following as evidence of administrative centralization and functional integration sufficient to rebut the single-facility presumption:

- The hospitals' policies, procedures, and personnel decisions were made at one location;
- Job classifications, wages, and benefits were the same across the system;
- Job vacancies were posted on a system-wide basis, no preference was given to employees within the division where the opening existed, and employees were transferred or promoted to jobs in other divisions without loss of seniority;
- The facilities used a common job application form, and applicants were cross-referenced between divisions two or three times per week;
- Equipment and employees rotated between facilities; and

- A number of operational functions were conducted on a system-wide basis, including transportation, purchasing, warehousing, linen supply, and payroll.

The facts that were sufficient to establish the appropriateness of a multi-facility unit in West Jersey Health System are also present in the instant case. The geographic proximity of OHI's four acute care hospitals is nearly identical to that of the facilities in West Jersey Health System, and OHI has demonstrated an even greater degree of administrative centralization than that set forth above. Moreover, in West Jersey Health System, the Board found a multi-facility unit appropriate even though local division administrators and managers were responsible for hiring, firing, evaluating, scheduling, administering discipline, and settling grievances. In the case at hand, OHI's centrally-located administrators are charged with these responsibilities, which makes a multi-facility unit even more appropriate in this case.

Similarly, in Presbyterian/St. Luke's Medical Center, 289 NLRB No. 30 (1988), the Board held that the employer's three health care facilities constituted a single appropriate bargaining unit because of proximity and shared administrative practices, personnel, and labor relations. Job openings were posted system-wide, employee seniority accrued system-wide, and nurses were temporarily transferred among the three hospitals on an as-needed basis. Furthermore, there was a consolidation of medical services, as evidenced by the fact that patients were often transferred from one facility to another to take advantage of specialized care offered at a specific hospital. OHI has demonstrated the existence of each of these facts, which the Board found sufficient to establish the appropriateness of a multi-facility bargaining unit in Presbyterian/St. Luke's Medical Center.

In Montefiore Hospital and Medical Center, 261 NLRB 569 (1982), the Board found that a multi-facility bargaining unit of staff physicians was appropriate. In that case, the employer

provided health care services at two clinical campuses, referred to as West Campus and East Campus, each of which contained a number of hospitals. The employer's administrative structure was highly centralized: although each facility had a separate budget, ultimate control of financial and administrative matters pertaining to all employees rested with the corporate directors. As in the instant case, the corporate director for human resources was responsible for setting and administering personnel and labor relations policies, including those relating to wage guidelines, wage increases, job titles, grievance handling, and employee benefits. Additionally, there was a "moderate amount of temporary interchange . . . among doctors in the unified departments." Id. at 574. These factors, which were sufficient to uphold a multi-facility bargaining unit in Montefiore Hospital, are present to an even greater degree in the instant case.

In Mercy Hospitals of Sacramento, Inc., 217 NLRB 765 (1975), the Board found "considerable" functional and operational integration among the hospitals at issue. The four hospitals made up a single corporation with a single governing board controlling the facilities' overall operations. Although employees at all of the facilities were subject to uniform personnel and labor relation policies, filled out identical job applications and personnel forms, and shared common job classifications, wage scales, and benefit programs, each facility was separately administered and maintained a separate personnel department. Job vacancies were posted in all of the facilities and preference was given to current employees, who were permitted to transfer or be promoted to positions in any facility without losing seniority.

Like OHI's acute care facilities, the Mercy Hospitals of Sacramento shared common internal services such as laundry, receiving, purchasing, data processing, billing and accounting. The hospitals regularly interchanged supplies, equipment, and support personnel in connection with the operation of surgical and therapy services. Based upon the above facts, the Board found

that a multi-facility bargaining unit was appropriate.[14] Here, where OHI has demonstrated the existence of the same factors that justified a multi-facility bargaining unit in Mercy Hospitals of Sacramento, together with additional factors weighing in favor of such a conclusion, the Regional Director's Decision was erroneous in finding otherwise.

Finally, in Bay Medical Center, Inc., 218 NLRB 620 (1975), the Board likewise found appropriate a multi-site unit of two hospitals. In so doing, the Board noted the following indicia of functional integration:

- Common overall supervision;
- Common wages, benefits, duties, and job classifications;
- Open bidding by employees at both hospitals for jobs at either hospital; and
- Substantial employee transfers and integration between facilities, including the merger of several departments into single ones.

Again, OHI has demonstrated extensive administrative centralization – including the existence of each of the factors present in Bay Medical Center – which has previously been held sufficient to justify a multi-facility bargaining unit.

This review of relevant Board law makes clear what criteria are of significance in making a determination as to the appropriateness of a proposed multi-facility bargaining unit. Given that the record contains substantial evidence of OHI's administrative centralization and functional integration, especially in comparison to the ways in which the Region found OHI lacking at the time of the 1994 Decision, its is clear that a multi-facility bargaining unit comprised of non-

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[14]The NLRB's decision in Mercy Hospitals of Sacramento was reversed by the Ninth Circuit Court of Appeals, 589 F.2d 968 (9th Cir. 1978). However, the Ninth Circuit did not question the Board's determination that, under the facts of the case, a multi-facility bargaining unit would be appropriate, but instead focused on the validity of stipulations regarding bargaining units.

supervisory registered nurses at Heritage, Dearborn, Annapolis, and Seaway is the only appropriate bargaining unit.

CONCLUSION

On the basis of the foregoing discussion, argument, and authority, OHI respectfully submits (1) that the Employer's charge nurses are supervisors under the Act, and (2) that an election should have been directed in the multi-site unit advanced by the Employer. Consequently, it is respectfully requested that the Board grant this Request for Review and reverse the Region's Decision and Direction of Election.

Respectfully submitted,

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Date: February 18, 2002
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UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
SEVENTH REGION

OAKWOOD HEALTHCARE, INC.[1]

Employer

and **CASE 7-RC-22141**

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), AFL-CIO

Petitioner

APPEARANCES:

William M. Thacker and Claire S. Harrison, Attorneys, of Ann Arbor, Michigan, for the Employer.
Blair Simmons, Attorney, of Detroit, Michigan, for the Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record[2] in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.[3]

[1] The name of the Employer appears as amended at the hearing.

[2] The parties submitted briefs, which were carefully considered.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

The Employer, Oakwood Healthcare, Inc. (OHI) owns and operates a large network of hospitals and related health care enterprises. Its Oakwood Healthcare System (OHS) operates four acute-care hospitals[4]; neighborhood and occupational health care centers; specialty care centers for mammography, cardiac rehabilitation, sports medicine, and adolescent health; numerous foundations; and various ancillary services such as laboratories and pharmacies. The Petitioner seeks to represent a unit of approximately 220 registered nurses (RNs) employed at a single acute-care hospital, Heritage.

There is no history of collective bargaining among the acute-care hospital nurses at issue. However, in 1994 the Region, in Case 7-RC-20261 filed by the Michigan Nurses Association, conducted a single-facility representation election, and in 1995 a rerun election, among nurses at Heritage. The Michigan Nurses Association lost that election and a certification of results of election issues. For many years, OHMC's service and maintenance employees have been represented in a single unit by the American Federation of State, County, and Municipal Employees, AFL-CIO, and OHMC's licensed practical nurses have been represented in a single unit by the Licensed Practical Nurses League. Since 1967, the service and maintenance employees of Annapolis, Heritage, and Seaway have

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[3] The hearing was closed pending the receipt of Employer Exhibit 17, a comparison of hours worked by each employee overall and as a charge nurse. This document was received on January 15, 2002. Petitioner subsequently asserted by letter that the document is incomplete, as certain individuals are not included on the list. The Employer responded to Petitioner's letter asserting that certain of the employees listed by Petitioner were omitted as they are confidential employees, and for other reasons. The Employer's Exhibit 17 is not being accepted as a complete list of all employees, nor is the issue of whether certain employees are confidential being decided at this time, as no evidence was presented as to this issue at the hearing. Any disputes over the eligibility of certain employees can be handled by the challenge procedure at election. Exhibit 17 is admitted to the extent it shows on average the frequency that staff nurses may work as charge nurses. Petitioner asserted by letter that assuming Exhibit 17 is used only for this purpose, it has no objection. The document is received, and the record is closed.

[4] The hospitals include Oakwood Heritage Hospital (Heritage); Oakwood Hospital and Medical Center (OHMC); Oakwood Annapolis Hospital (Annapolis); and Oakwood Seaway Hospital (Seaway).

been represented by Local 79, Service Employees International Union, AFL-CIO (hereinafter Local 79) in a multi-facility unit.

In 1999, Local 79 filed a petition in Case 7-RC-21970 to represent RNs at Annapolis. A hearing was held over the issue of whether a single facility unit was appropriate, or whether the only appropriate unit would be a system-wide unit of all registered nurses at Annapolis, Heritage, OHMC, and Seaway. A decision issued on May 9, 2001, wherein the undersigned found that a single facility unit, consisting only of RNs at Annapolis, was appropriate. The Employer filed a request for review, but Local 79 withdrew its petition before any decision by the Board. In the current case, the hearing officer took administrative notice of the entire record in the previous cases.

The Employer raises two issues in this matter. First, the Employer contends, as it did in Case 7-RC-21970 with respect to Annapolis, that a single-facility unit at Heritage is inappropriate, and that the only appropriate unit is a system-wide unit of all RNs at Heritage, Annapolis, OHMC, and Seaway. The parties stipulated that there are no material differences between Heritage and Annapolis as to the evidence regarding the appropriateness of a multi-site unit, and incorporated the record from the prior proceeding in 7-RC-21970 and 7-RC-20261 as the basis for determination in the instant matter.

Second, the Employer contends that the proposed bargaining unit is inappropriate because the RNs (referred to as staff nurses) sought by the Petitioner are supervisors within the meaning of the Act. The Employer submits that the primary indicia that the RNs are supervisors is their responsibility when serving as charge nurses to assign and direct other nurses, and adjust grievances.

OHI's president and chief executive officer is Gerald D. Fitzgerald. Directly under him is Joseph Diederich, the chief operating officer, who has overall responsibility for health care delivery at the four acute-care hospitals as well as numerous ambulatory, long-term care, and care management facilities and foundations. Due to the complicated series of transactions by which OHI acquired Annapolis, Heritage, and Seaway, those three acute-care hospitals are still nominally owned by a separate subsidiary corporation, Oakwood United Hospitals, Inc. However, OHI manages those hospitals, leases their real property and physical assets, and employs their staffs. In contrast to the situation prevailing at the time of the 1994 Heritage decision and election, Oakwood United Hospitals, Inc. no longer maintains a separate board or management structure.

Of the four acute-care hospitals, OHMC, by far the largest facility, offers the widest range of services, including, but not limited to, in-patient mental health, obstetrics, specialized cardiac care, neurosurgery, neonatal intensive care, cancer

center, and pediatrics. Neither Annapolis nor Heritage offers obstetrics, and Heritage does not offer pediatric services. Heritage, alone among the four hospitals, has a pain clinic, sleep lab, and in-patient rehabilitation unit. Although each hospital operates its own laboratory to perform emergency tests requiring a result in two hours or less, all routine lab tests are performed at OHMC. OHI supports its hospitals and network health care facilities with centrally handled materials management, laundry, patient billing, medical transcription, accounting, payroll, marketing, public relations, human resources, and risk management services. Each of the acute-care hospitals runs its own kitchen, but certain basic foodstuffs such as gravies and soups are prepared at OHMC and then distributed. All OHI job candidates and employees are tracked in a system-wide computer database called PeopleSoft.

Heritage Hospital is an acute care hospital with 257 licensed beds. Heritage has medical surgical areas, Intensive Care and Intermediate Care, ER and OR services; rehab services, and psychiatric/behavioral health services. These services are divided into the following units within the hospital: Medical/Surgical West (MSW), Medical/Surgical East (MSE), Behavioral Health (BH), Post Anesthesia Care Unit/Recovery (PACU); Rehab, Intermediate Care Unit (IMU), Intensive Care Unit (ICU), Emergency Department (ER), and Operating Room/Anesthesia Department (OR). The pain clinic at Heritage is an outpatient clinic for patients who are being treated for chronic pain.

The corporate Human Resources Department is headed by Executive Vice President John Furman, who reports directly to President/CEO Fitzgerald. Under Furman are Corporate Director of Employee and Labor Relations Ed Frysinger and Corporate Director of Compensation and Benefits Dan Smorynski. Director of Employee and Labor Relations Verna Bastedo as well as the currently unfilled directors of staffing and human resources report to Frysinger, while a benefits manager, compensation manager, and pension analyst report to Smorynski. The corporate Human Resources Department has developed and issued standardized personnel forms for virtually all events and actions. It has promulgated uniform attendance, leave, and transfer policies and procedures. With the approval of senior management councils, it has formulated, and when necessary it revises, system-wide fringe benefit packages and wage ranges for every job classification. Local managers must use the prescribed forms and may not depart from the established policies, procedures, benefits, and wages. A common employee handbook summarizing these employment matters applies to workers at the four hospitals as well as other OHS facilities and OHI's home care division.

Director of Employee and Labor Relations Bastedo is OHI's labor contract negotiator. She also supervises human resource personnel at individual sites. Stationed at Annapolis are two human resource clerical employees, one

employment recruiter, and one human resource manager; at Heritage, two human resource clericals, a part-time employment recruiter, and a part-time human resource manager; at Seaway, two part-time human resource clericals, a part-time employment recruiter (shared with Heritage), and a part-time human resource manager (shared with Heritage); and at OHMC, three human resource clericals, five or six employment recruiters, and one human resource director. Bastedo assigns human resource professionals to perform tasks at facilities different from their home base when the need arises. On-site human resource staff members answer questions, direct inquiries, and implement but may not modify corporate employment policies and practices. Except for OHMC, which stores employee personnel files at a corporate office known as Village Plaza, the hospitals maintain their respective personnel files.

The corporate office of staffing coordinates the recruitment of nurses on a system-wide basis. OHS advertises all job openings throughout its system on OHI's web site and in various print and electronic media. It sends recruiters to job fairs. Nurse recruiters concentrate on assigned geographical areas, but will direct interested applicants to job openings at any site. After completing a standard application form, a job candidate receives an initial screening by a nurse recruiter. This involves a preliminary inquiry into minimum qualifications and a background criminal check. The recruiter sends all candidates who pass this minimum threshold to be interviewed by the clinical manager -- the on-site, first-line supervisory nurse -- into whose unit the candidates seek entry. The interviews conducted by the clinical manager explore the applicants' experience levels and clinical competence. An Employer witness testified that the final hiring choice is normally the product of consensus between the recruiter and clinical manager. As far as the record reveals, however, the recruiter does not participate in the clinical manager's interview regarding specific job qualifications. An Employer exhibit culled from one of many written procedures approved by a multi-site body called the Acute Care Nursing Operations Council states that the clinical manager selects the most qualified candidate and informs the nurse recruiter of the decision.

All employees covered by the handbook described above are subject to the same progressive disciplinary system. For minor infractions, the progression is counseling, a first and second written warning, a three- or five-day suspension, and finally termination. Major infractions may meet with more severe punishment. The nurse's on-site immediate supervisor undertakes the counseling and initiates the warnings. According to the handbook, suspension decisions originate with local nursing management, but must be reviewed by human resource personnel on site in order to assure consistent and equitable treatment. Terminations require the approval of a corporate vice president. The record does not reveal whether, or how often, corporate human resource officials countermand nursing managers'

suspension and discharge recommendations. All discipline is recorded on standard corrective action report forms and filed with the Human Resources Department.

The same employee handbook outlines a problem resolution mechanism for use at the hospitals and elsewhere. Steps one and two of the procedure are meetings between the aggrieved nurse and on-site nursing supervision. Step three involves a human resource representative who may be either based at the aggrieved nurse's hospital or imported from another site. Directors of Employee and Labor Relations Bastedo or Frysinger address grievances at step four. If the dispute arises out of a suspension or termination, impartial arbitration is available as a fifth and final internal step.

The chief administrative officer at Heritage is Rick Hillbom, who reports to Diedrich, the chief operating officer of OHI. Brenda Theisen, nursing site leader and director of patient care services at Heritage, reports to Hillbom regarding daily operations at Heritage. Theisen also reports to Barb Medvec, the chief nursing officer of OHS. The nursing site managers at Seaway, OHMC, and Annapolis also report to Medvec.[5] Medvec and Diedrich do not work on site at the Heritage facility. As the nursing site leader at Heritage, Theisen is responsible for anything having to do with nursing care that is delivered by the hospital, although she does not directly supervise nurses on a day-to-day basis.

Reporting to Theisen at Heritage are clinical supervisors (also known as nurse supervisors or house supervisors) and clinical managers (also known as nurse managers).[6] Clinical supervisors generally work on off shifts, such as afternoon shifts, midnights, holidays, and weekends. When they work they cover the entire hospital, nursing as well as every department within the hospital. Only one clinical supervisor works on a particular shift at a given time. The clinical supervisors do not spend too much time in a particular unit because they are overseeing the entire hospital. They spend considerable time in the ER, because they have to attend to any code (code blue, respiratory or cardiac arrest of a patient) that occurs. They also look at staffing for the next shift, call agencies or additional staff if needed, and document call-offs if someone is calling in sick. They also address any problems that may arise during their shift (i.e., fire alarm going off, flood.) When on duty, the clinical supervisor is the highest ranking administrative officer in the facility.

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[5] The parties stipulated at the hearing that Hillbom, Theisen, Medvec, and Deidrich are all statutory supervisors within the meaning of the Act based on their authority to discipline and independently direct employees.

[6] The parties stipulated, and I find, that clinical supervisors and clinical managers are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct employees.

Clinical managers are responsible for several units in distinct geographical areas within the hospital. Clinical managers are all RNs. They normally work the day shift, and they oversee the units that they are responsible for as far as developing a unit budget, finalizing schedules, and drafting schedules that have been submitted by the nursing staff. They work on development of policy for their units, and attend meetings, corporate as well as site meetings and department meetings. They are not regularly engaged in actual clinical work/nursing functions. They each have an office located within one of their units. They are on call 24 hours a day, and address the day-to-day issues and problems that arise within their units, assuming such problems cannot be addressed at a lower level. Clinical supervisors and clinical managers are salaried positions.

There are eight assistant clinical managers (also referred to as assistant nurse managers or ACMs) who report to the nurse managers.[7] The ACMs are part of the management team and as such attend meetings, assist with schedules, and cover the clinical manager's responsibilities when the clinical manager is not in the building doing administrative functions. Not every unit has an ACM. The clinical managers direct the duties of the ACM. They work various shifts, determined by the clinical manager with whom they work. The position was created to enable the clinical manager to cover multiple units. The ACMs also handle day-to-day issues and problems if needed.

All registered nurses at the hospitals report directly to on-site nursing supervisors. With the recent advent of "service line" reporting configurations, however, the upper reach of supervisory hierarchy for nurses in certain specialties includes individuals who oversee that nursing specialty at more than one site. Nonetheless, the development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader. A communication chain of command is contained in several written directives issued by the corporate Human Resources Department and approved by the Acute Care Nursing Operations Council. These policies specify that a nurse or charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor. The latter contacts the nursing site leader, who consults with the site administrator, service line leader, or risk manager as deemed necessary.[8]

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[7] The parties stipulated, and I find, that ACMs are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct other employees.

[8] Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines." It is clear that out of a nursing staff at Annapolis of 232, 65 to 70 nurses are in "service lines."

Staffing and scheduling guidelines emanate from the corporate Human Resources Department. These precepts are further refined by the Acute Care Nursing Operations Council. The work schedule for nurses on each nursing unit must be posted for four weeks. The corporation has adopted what is considered a standard work day, and also offers nurses the option of working alternative schedules. Within these parameters, specific choices of unit shifts (days, evenings, midnights, or rotation) and hour patterns (4-hour, 8-hour, 10-hour, or 12-hour) are established by the unit's clinical manager. Requests for shift changes must be made in writing and submitted to the clinical manager. Employees may adjust their schedules by trading with colleagues, but all trades must be requested of and approved in advance by the clinical manager. The amounts of allotted vacation time, sick leave, and personal time are centrally prescribed, but specific requests for vacation time and other leave are submitted to and acted upon by the nurse's immediate site supervisor. In particular, the clinical manager sets the limit on the number of simultaneous vacations that she will allow.

OHS enforces an across-the-board policy forbidding mandatory overtime, but overtime will be scheduled and offered in emergencies. The clinical manager or clinical nurse supervisor determines whether an emergency exists, and all overtime must be approved in advance by those individuals. The corporation has a uniform attendance program that correlates discipline with the number of unexcused absences. The clinical manager has discretion to characterize an "emergency" absence as excused and an undocumented absence as unexcused.

Staffing guidelines are centrally determined, and are based on prescribed criteria such as patient census and acuity. The clinical nurse supervisor is responsible for assuring that adequate staff is available and for initiating the use of overtime, system or in-house flex pool nurses, or outside agency nurses to cover staffing shortages. Each hospital's nursing site leader maintains 24-hour accountability and availability to assure that appropriate staffing levels are continuous.

An inter-site nursing leadership council has devised detailed job descriptions for each nursing position. As noted above, each job has a set wage range from which site managers may not vary. A newly hired or transferred nurse is assigned a wage rate within the range based upon her level of experience, in accordance with a centrally determined grid. How years of experience for this purpose are counted or weighted is not disclosed in the record. The wage ranges for each job classification are uniform across the four acute-care hospitals.

All employees subject to the handbook receive periodic performance appraisals, prepared by immediate site supervisors on centrally prescribed forms. The supervisor assigns a numerical rating in specific areas, and the individual

ratings are converted, in accordance with a predetermined formula, into an overall score. As stated in the handbook, all employees with a final score of 100 or more are entitled to whatever across-the-board pay increase that the Employer chooses to implement. Any applicable pay increase will be the same for all eligible employees, regardless of the exact appraisal score.

The handbook states that OHS encourages inter-corporate voluntary job transfers as a way for employees to seek personal advancement. All employees with six months seniority in their present position, who have been free of disciplinary suspensions within the last two years, are eligible for a voluntary transfer. A nursing site leader may grant an exception to the six-month requirement. A nurse initiates a voluntary transfer by completing a transfer request form and submitting it to the Human Resources Department. The clinical manager of the unit being requested receives a copy of such request. As a position becomes available, the clinical manager interviews all applicants who meet the foregoing minimal requirements. Prior to making her decision, the clinical manager of the receiving unit will request background information from the transferring clinical manager. The receiving clinical manager makes the final selection, utilizing defined clinical criteria. A nurse who transfers to a new site may carry her accumulated sick and vacation time, but not unused holidays or personal days. Her length of service will follow her to the new site for the purpose of determining eligibility for service awards, vacation, sick time, and health benefits.

Nurses normally may not use their corporate seniority to "bump" into the position of a less senior nurse at a different site. Such bumping is theoretically permitted only in the case of a reduction of force *and* if the two nurses are in the same service line. Whether these twin conditions have ever been met so as to trigger an occasion of bumping was not disclosed in the record.[9]

During the 14.5 month period preceding the hearing in Case 7-RC-21970, 9 nurses permanently transferred from Annapolis to another OHS acute-care hospital, and 24 nurses permanently transferred to Annapolis. In relation to the 232-nurse complement at Annapolis, this is a transfer rate of 14%. Of the 24 in-coming transfers, 14 were occasioned by the closing of Beyer Hospital, an acute-care facility formerly part of Oakwood United Hospital, Inc. The record does not reveal the reason for the other Annapolis transfers, or whether they were voluntary or

[9] The Employer's closure of the Annapolis-Westland behavioral health facility in 1997 affected 20 nurses. According to Verna Bastedo, their unionized status meant that OHS' bumping procedures did not apply. Nonetheless, 13 of the 20 nurses were offered jobs in OHS' acute-care hospitals. Obstetric units in Seaway and Beyer, a now defunct facility, also closed in recent years. There is testimony that affected nurses were absorbed into the corporate system and retained their seniority, but no indication that they displaced other nurses via bumping.

involuntary. If the Beyer closing did not occur during the selected time span, Annapolis' transfer rate would be 8%. During the same period, 24 nurses made permanent transfers among OHMC, Seaway, and Heritage. In addition, OHMC, Seaway, and Heritage also absorbed 23 nurses due to OHI's closing of Beyer Hospital. Excluding the Beyer transfers as non-recurring events yields a transfer rate among OHMC, Seaway, and Heritage of less than 1.5%.

During the 5-month period ending shortly before the hearing in Case 7-RC-21970, there were 7 temporary transfers of nurses from other OHS hospitals into Annapolis, and 63 temporary transfers of Annapolis nurses to other hospitals. The intervals of time spent working at the outside site varied; most exceeded eight hours. The preponderance of such temporary transfers was due to the assignment of flex pool staff, nurses who receive premium pay in exchange for working flexible schedules. The reasons for these temporary transfers were not explored at the hearing.

Other than the contact occasioned by the transfers described above, nurses from one site may encounter nurses from another during the corporate stage of new employee orientation. This program, which follows a uniform syllabus, takes place at a central corporate office and is attended by all newly hired nurses. Nurses also receive site-specific orientation upon being hired or transferred.

At Heritage, there is some variability with the staff nurse position depending on the department, but in general, there is one written job description that generally applies to RNs working throughout the hospital. The description states that RNs are responsible for providing direct care to patients utilizing the nursing process under general direction, guiding and supervising nursing personnel, collaborating with other health care professionals, and coordinating ancillary staff.

The clinical manager reviews the job description with the nurses when they have their annual performance appraisals. Among other things, the RNs are evaluated in their performance appraisals on their ability to act as a resource person for trouble-shooting, contributing to the professional growth of peers, colleagues, and others; precepting and mentoring; and ability to perform as a charge RN.

The type of work performed is basically what is dictated by their profession, based on the education and experience of an RN. They follow doctors orders, which are usually written instructions as to what type of treatment is needed, including administering blood tests, passing medications, and observing patients more closely. For every task performed by a nurse, there is a very specific policy and procedure in writing. However, long-time RNs generally do not need to refer to the policy and procedure manuals because of their experience, and many of the RNs working at Heritage have worked for the Employer for over 10 years.

The employees working with the RNs are typically employees such as mental health workers, who assist in the Behavioral Health Department; licensed practical nurses (LPNs), who are licensed to perform certain nursing tasks but not the full duties of an RN; nursing assistants, who generally work with and assist RNs with daily tasks; desk secretaries, who answer telephones, answer call lights from patients, and enter orders for patients; nurse externs, who are nursing students who have not yet graduated; graduate nurse externs, who are nursing students who have graduated but have not yet passed their exams or received their license; OR Techs and Surgical Techs, who assist staff nurses with the care of a patient undergoing surgical intervention, and ER techs and paramedics, who work in the Emergency Department to assist the staff working in the ER.[10] The job descriptions of the majority of these positions state that they work under the direction of the RN. Most are also evaluated on whether they follow directions appropriately to meet the demands of the unit and the staff. The RNs are responsible for anyone else working under the RN level. This responsibility of "guiding and supervising nursing personnel" and/or "demonstrates effective leadership and professional development" is a criteria under which RNs are evaluated during their performance appraisals.

RNs may assign mental health workers, nursing assistants, techs, or other less skilled employees to do certain tasks that are within their ability. For example, they may assign a mental health worker to work with a group of patients, or they may instruct a nurse assistant to give a patient a bath, walk a patient to the bathroom, or give a patient a meal. They assign these tasks to the nurse assistants because that is what a nursing assistant's job is - to assist the staff. If something more important comes up, the RN may interrupt that task and assign the nurse assistant to something else. Nursing assistants and techs are also aware of certain jobs they can do and will take it upon themselves to do these jobs, without first being told. It would be insubordination if a nurse assistant refused to listen to the RN, and the RN could go to a superior to intervene. However, it could be proper for an assistant to refuse a task for good reason, such as if they were busy on a different assignment. Regardless, no situation has arisen where an assistant or other worker refused to perform a task. If this did occur, RNs do not believe that they have the authority to do very much about it other than going to the clinical manager, as they have no role in disciplining employees.

The RNs do not rotate shifts. They work straight shifts; day, afternoon, or midnight, or 12-hour shifts, which are ordinarily day shifts (7:00 a.m. to 7:00 p.m.) or midnight shifts (7:00 p.m. to 7:00 a.m.). However, they do take turns rotating the

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[10] The nursing assistants are the only employees mentioned in this group that are represented by a union, Local 79.

responsibility of charge nurse. On every shift in each unit, except the pain clinic, there is one RN assigned to work as a charge nurse. At times, however, assistant clinical managers have filled in as charge nurses. In particular, in late 2001 assistant managers filled in as charge nurses to decrease agency nurse hours.

Rotating charges are individuals who occasionally take charge nurse responsibilities in a unit. The frequency with which it happens depends on the size of the unit and the number of RNs that occasionally rotate. A permanent charge is a person who has requested to and agreed to be in permanent charge; each time they work, they work as a charge nurse. The duties of a charge nurse, whether rotating or permanent, are the same. RNs are paid hourly. They earn $1.50 more per hour when they are working as a charge nurse.

In the IMC Department, if the assistant nurse manager is not there to take charge, they rotate the responsibility of charge nurse. Sometimes it is assigned by the clinical manager on the schedule, and sometimes it is not. If it is not assigned, then they take turns. RN Coffee testified that she is a charge nurse approximately one to two times during a two-week schedule.[11] Similarly, RN Welch testified that her work schedule in the ER indicates when she is assigned to the charge nurse responsibility. The schedules come out in a four-week time frame. As with Coffee, in a two-week time frame, she is usually in charge once or twice.

RNs must have at least one year of nursing experience to act as charge nurses. RNs learn the responsibilities of a charge nurse through their education, and by initially working with a preceptor, or mentor. Preceptors will work along with the RNs as charge nurses until the RNs are able to perform the job on their own.

Some RNs choose not to be in charge at all and there is not necessarily a permanent charge on each unit. However, a review of Employer's Exhibit 12 reflects that a majority of RNs, with the exception of those working at the Pain Clinic and in the Operating Room, take turns rotating as charge nurse. It appears from the record that most of the RNs who are not rotating are newer employees who are not yet ready to take on the charge nurse responsibilities. Also shown by Exhibit 12 is that only approximately 11 nurses are permanent charges.[12] In the Behavioral Health Unit, every RN is a rotating charge or a permanent charge. Where there is a permanent charge on a particular shift, the rotating charges on that shift take turns acting as a charge nurse on the days when the permanent charge is not working.

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[11] Coffee works part-time, which is five days out of every two weeks. As such, she is charge nurse approximately two out of every five days that she works.

[12] The majority of the permanent charges work in the Behavioral Health Unit.

shift take turns acting as a charge nurse on the days when the permanent charge is not working.

Charge nurses are responsible for overseeing the unit for the shift that they are working, with the staff who are working the unit that day. They do the assignments of all the staff that are working on that shift. They monitor in general all the patients that are in the unit that day, and meet with physicians if a physician has an issue with a nurse or with a patient. They also meet with patients or family members who have a complaint. Some responsibilities vary within each unit. If a variance occurs during a shift, such as a medication error, patient fall, or any other incident, a form called a "quality assessment report" is filled out. The charge nurse is responsible for following up with the incident by examining the patient, and signing the report as the "person in charge." If necessary, the charge nurse will call a physician to evaluate the patient.

RNs are sometimes pulled to work in other units, but not if they are assigned to work on charge duty. If it is a nurse's turn to be pulled, and she is on charge duty, she will stay on that shift and go the next time. When RNs are pulled to work in other units, it usually happens at the start of the shift. The charge nurse is informed that a nurse is needed in another department, and is given the names of the nurses who are to be pulled by the clinical supervisor from the previous shift. Charge nurses can also be called in the middle of the shift – a supervisor may inform the charge nurse that one of her nurses is needed in another unit. The charge nurse cannot refuse that request. If the charge nurse refused to send someone, there would be disciplinary action. The charge nurse does not assign employees to shifts; that is done by a staffing office. When the charge nurse comes in, she is handed a list (prepared by the supervisor on the previous shift) of the nurses who are supposed to be working that day on her shift. If nurses on the list do not show up, the charge nurse calls the staffing office to find out where that person is.

OHS has a policy for the assignment of nursing personnel to provide adequate numbers of licensed staff and other personnel to deliver care to patients. Under this policy, assignments are to be made in accordance with the patient's need. In making assignments, the charge nurse must determine the acuity of the patient and determine the level of skill required to care for the patient – i.e., RNs can perform certain tasks that cannot be performed by LPNs, etc. Level of experience of the nurse, determining which nurses work well together as a team, as well as other activities that a particular nurse may also be responsible for, are also considered. On occasion, assignments will be changed mid-shift; for example, if there is a change in a patient's condition such that different care is warranted. The charge nurse also assigns nursing assistants or mental health workers either to particular patients or to work alongside specific RNs. After receiving their general assignment, the RN and/or the charge nurse may assign them more specific tasks

nurses when they would like to take their break, and their main goal in assigning breaks is to make sure the unit is covered at all times.

At times RNs may complain about particular assignments. The charge nurse can re-evaluate and make changes in assignments if appropriate. This could occur if a patient requires more work than expected, or if a patient's condition changes which requires more treatment or attention However, the record does not indicate any instances of a serious conflict based on job assignments. Furthermore, RNs usually work together to help each other out, as a common courtesy of their profession. If RNs need help with a patient, they may go directly to another nurse and ask rather than going to the charge nurse. Many of the tasks handled by the charge nurse, including complaints of family members, can be handled by any RN. One RN testified that she does not interact any differently with other RNs on staff when she is a charge nurse compared to when she is not.

Some charge nurses may take patient assignments in addition to their other responsibilities. Whether or not a charge nurse takes an assignments typically depends on what department they work in and on what shift they work. Charge nurses on each shift are responsible for deciding whether or not they take assignments. Charge nurses frequently do take patients, although they will often take fewer patients than the other staff nurses on duty.

The assignment of staff nurses to patients is much more perfunctory in practice than the Employer's written assignment policy indicates. The assignment of work is generally rotated, or based on where a person worked the previous day. When making assignments as a charge nurse, reference is made to a staffing sheet showing where everyone worked the day before. It usually takes only a few minutes to do the assignments. There was testimony that the main responsibility of the charge nurses is to be familiar with what is going on in their particular units, and to basically be the go-to person for questions or issues that arise. For example in the ER, the charge nurse has to answer to the clinical supervisor's or manager's inquiries about whether there will be patient admissions. This will determine whether extra staffing is needed for a particular unit, such as ICU.

When the nurses arrive for their shifts in the IMU, they all listen to the report from the charge nurse of the previous shift. Then the charge nurse makes the assignments by asking who knows which patients have the highest acuity (these patients are referred to as the "completes"). They get a slip from the staffing office showing who is supposed to be there that day. The charge nurse then makes out the assignments. First, the completes are divided up evenly. After that, they look at who was there the day before, and try and give them the same assignment they had in order to maintain continuity. In IMU, nurse assistants make out their own assignments.

The charge nurse in IMU is also responsible for assigning beds to new patients or transfers from ICU. When determining where to assign the new patient as far as the staff is concerned, the charge nurse will go by who did an admission the day before – or, who currently has three patients instead of four. If necessary, the charge nurse may assign the patient to herself. If everyone had a full load, she would go to the manager. It also becomes necessary to reassign patients to different staff, if, for example, there is a personality conflict between a nurse and a patient. This could be handled by asking another nurse if she would take the patient. It is questionable whether the charge nurse has the authority to force another nurse to take another patient.

Generally, it is the clinical manager who hires, fires, and handles conflicts within the unit. They also handle performance evaluations, finalize schedules, and handle staffing issues and patient complaints. The assistant manager also does these things. Charge nurses do not make the decision to hold someone past the end of their shift if they are short staffed, nor do they authorize overtime. Charge nurses can be, and have been, disciplined by clinical managers.

Congress instructed the Board to make unit findings so as "to assure to employees the fullest freedom in exercising the rights guaranteed by this Act." 29 U.S.C. §159(b). It is axiomatic that nothing in the Act requires a bargaining unit to be the *only*, or the *ultimate*, or the *most appropriate* grouping. ***Overnite Transportation Co.***, 322 NLRB 723 (1996); ***Capital Bakers***, 168 NLRB 904, 905 (1967); ***Morand Bros. Beverage Co.***, 91 NLRB 409 (1950), enfd. 190 F.2d 576 (7th Cir. 1951). A union need not seek representation in the most comprehensive grouping of employees unless an appropriate unit compatible with the union's request does not exist. ***Purity Food Stores***, 160 NLRB 651 (1966); ***P. Ballantine & Sons***, 141 NLRB 1103 (1963). A union's desire is always a relevant, although not a dispositive, consideration. ***E. H. Koester Bakery & Co.***, 136 NLRB 1006 (1962).

A single facility of a multi-location employer is a presumptively appropriate unit. ***Hegins Corp.***, 255 NLRB 160 (1981). The Board, with court approval, uses the same single-facility presumption in fashioning health care units. ***Manor Healthcare Corp.***, 285 NLRB 224 (1987); ***Presbyterian University Hospital v. NLRB***, 88 F.3d 1300, 1309 (3rd Cir. 1996); ***Staten Island University Hospital v. NLRB***, 24 F.3d 450, 456-467 (2nd Cir. 1994).

Manor Healthcare mandates consideration of traditional factors in deciding whether the presumption has been overcome. Such factors are geographic proximity, bargaining history, employee interchange and transfer, functional integration, administrative centralization, and common supervision. Thus, the presumption is normally overcome only if employees from the single location have

been blended into a wider unit by bargaining history, or if the single location has been so integrated with a wider group as to cause it to lose its separate identity. *Heritage Park Health Care Center*, 324 NLRB 447, 451 (1997), enfd. 159 F.3d. 1346 (2nd Cir. 1998); *Passavant Retirement & Health Center*, 313 NLRB 1216 (1994); see also *Centurion Auto Transport*, 329 NLRB No. 42 (1999). The presumption may also be rebutted in the health care setting by a showing that approval of a single-facility unit will increase the kinds of disruptions to continuity of patient care that Congress sought to prevent in cautioning against proliferation of units in the health care industry. *Mercywood Health Building*, 287 NLRB 1114, 1116 (1988), enf. denied on other grounds sub. nom. *NLRB v. Catherine McAuley Health Center*, 885 F.2d 341 (6th Cir. 1989).

The Employer has undertaken a number of measures to streamline its enterprises. This has resulted in centralization of many administrative functions, including marketing, purchasing, recruitment, payroll, and human resources. Wages, benefits, and disciplinary procedures exhibit a high degree of uniformity. The advent of service lines affects the reporting structure by making certain mid- and high- level nursing supervisors responsible for coordinating nursing services at more than one facility.

Nonetheless, each nurse at Heritage reports to a supervisor on site, and on-site management still exercises significant autonomy over the Heritage nurses' work lives. Clinical managers control work schedules, choice of shifts, and hours. They grant or deny leave requests, determine how many vacations will be permitted at a time, and decide whether overtime will be worked. Management at Heritage interviews and selects new hires and transferees from pools of eligible nurses. A clinical manager has some discretion in the classifying of an absence as excused or unexcused.

Heritage management and supervisory personnel initiate all disciplinary actions, and, as far as the record reveals, take conclusive unilateral action with respect to counseling and written warnings. Similarly, Heritage management has the authority to resolve grievances at the first two steps of the dispute resolution procedure. A nurse's job performance appraisal by her nurse manager determines her eligibility for any across-the-board wage increase. When professional, operational, and ethical problems arise, nurses are specifically instructed to follow the chain of command that originates at the first level of nursing management at the site, and travel through the site's hierarchy to the nursing site leader.

The foregoing recital demonstrates that within the Employer's framework, Heritage nurse management retains significant authority. The presence of local control is a decisive factor and overcomes even strong evidence of centralization. *NLRB v. HeartShare Human Services of New York, Inc.*, 108 F.3d 467 (2nd Cir.

1997), enforcing 317 NLRB 611 (1995) (finding single facility appropriate). In ***RB Associates***, 324 NLRB 874 (1997), the Board, relying in part on the existence of local supervision, found a single hotel unit to be appropriate, despite the close proximity of other hotels; common personnel policies, handbook, benefits, rules, and regulations; central hiring; commonly conducted orientation; intercession of a corporate human resource director in hiring, discipline, and performance evaluations; identical employee skills and functions; and open transfers without loss of benefits or seniority. See also ***Children's Hospital of San Francisco***, 312 NLRB 920 (1993), enfd. sub. nom. ***California Pacific Medical Center v. NLRB***, 87 F.3d 304 (9th Cir. 1996).

There is no relevant bargaining history in this case militating against the appropriateness of a single-facility finding. The evidence does not show, nor does OHI contend, that a single-facility unit finding will threaten the continuity of patient care. ***Hartford Hospital***, 318 NLRB 183, 193 (1995), enfd. 101 F.3d 108 (2nd Cir. 1996).

The evidence of interchange, as introduced in Case 7-RC-21970, is limited. The majority of permanent transfers in the period under examination was caused by the closure of an acute-care hospital. The remaining permanent transfers were statistically negligible in the overall unit sought by the Employer. Many more temporary transfers were attributable to the use of flex pool nurses than to migration of the stationary nursing corps.

I find the cases relied upon by the Employer to be distinguishable. In ***West Jersey Health System***, 292 NLRB 749 (1989), the Board had a concern, absent here, that unit fragmentation would adversely affect patient care services. The record in ***West Jersey*** also demonstrated considerably more employee interchange, with 147 permanent transfers in a 14-month period, regular temporary rotation of unit employees to other facilities, and the availability of seniority bumping rights.[13] In ***Presbyterian/St. Luke's Medical Center***, 289 NLRB 249 (1988), the Board found that a "significant number" of transfers had occurred and that physicians need not make separate applications, as they do here, to be admitted to practice. In ***Montefiore Hospital***, 261 NLRB 569 (1982), neither party sought a single-facility unit, and the Board's task was to delineate an appropriate unit among competing multi-location groupings.

The Employer has adduced evidence tending to show that a unit comprised of its four acute-care hospitals may be appropriate. However, that a wider unit may

[13] In *West Jersey*, employees could transfer by exercising bumping rights. At the Employer , no voluntary transfers may be accomplished by bumping. Rather, seniority may be exercised on an inter-site basis only within the same service line during a reduction in force.

be appropriate does not imply that a narrower one is inappropriate. ***Children's Hospital of San Francisco***, supra at 928. The Employer bears the burden of establishing that consolidation and centralization have destroyed Heritage's identity. For the reasons discussed above and based upon the entire record, I find that the Employer has not met that burden.

Section 2(3) of the Act excludes from the definition of the term "employee" "any individual employed as a supervisor." Section 2(11) of the Act defines a "supervisor" as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is to be interpreted in the disjunctive and the possession of any one of the authorities listed in that section places the employee invested with this authority in the supervisory class. ***Ohio Power Co. v. NLRB***, 176 F.2d 385 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949); ***Allen Services Co.***, 314 NLRB 1060 (1994).

On May 29, 2001, the Supreme Court issued its decision in ***NLRB v Kentucky River Community Care***, 532 U.S. 706, 121 S.Ct. 1861, 167 LRRM 2164 (2001), wherein the Court upheld the Board's longstanding rule that the burden of proving Section 2(11) supervisory status rests with the party asserting it. See ***Ohio Masonic Home***, 295 NLRB 390, 393 fn.7 (1989); ***Bowen of Houston, Inc.***, 280 NLRB 1222, 1223 (1986). However, the Court rejected the Board's interpretation of "independent judgment" in Section 2(11)'s test for supervisory status, i.e., that registered nurses will not be deemed to have used "independent judgment" when they exercise "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards." 121 S.Ct. at 1863. Although the Court found the Board's interpretation of "independent judgment" in this respect to be inconsistent with the Act, it recognized that it is within the Board's discretion to determine, within reason, what scope or degree of "independent judgment" meets the statutory threshold. See ***Beverly Health & Rehabilitation Services***, 335 NLRB No. 54 (Aug. 27, 2001). However, the Court did agree with the Board in that the term "independent judgment" is ambiguous as to the *degree* of discretion required for supervisory status and that such degree of judgment "that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and

regulations issued by the employer." 121 S.Ct. at 1867. In discussing the tension in the Act between the Section 2(11) definition of supervisors and the Section 2(12) definition of professionals, the Court also left open the question of the interpretation of the Section 2(11) supervisory function of "responsible direction," noting the possibility of "distinguishing employees who direct the manner of others' performance of discrete tasks from employees who direct other employees." 121 S.Ct. at 1871. See ***Majestic Star Casino***, 335 NLRB No. 36 (Aug. 27, 2001).

For instance, direction as to a specific and discrete task falls below the supervisory threshold if the use of independent judgment and discretion is circumscribed by the superior's standing orders and the employer's operating regulations, which require the individuals to contact a superior when anything unusual occurs or when problems occur. ***Dynamic Science, Inc.,*** 334 NLRB No. 56 (June 27, 2001); ***Chevron Shipping Co.***, 317 NLRB 379, 381 (1995).

In the instant case, there is no evidence that the RNs, whether acting as a charge nurse or a staff nurse, have independent authority with respect to the hire, promotion, demotion, layoff, recall, reward, or discharge of employees. They do not make staffing decisions, and they do not authorize overtime. The Employer rests its claim of supervisory authority primarily upon other indicia, i.e., the alleged ability to adjust grievances, and the alleged authority to assign and direct the work of less skilled employees.

There is no evidence that the charge nurses are empowered to adjust any formal employee grievances. Charge nurses are not part of the grievance process outlined in the Local 79 contract covering other members of the nursing staff. For the most part, complaints or disputes brought by the nursing staff to the charge nurse that cannot be resolved quickly in an informal manner are relayed to supervision. See ***Ken-Crest Services***, 335 NLRB No. 63 (Aug. 27, 2001). Furthermore, there is a lack of evidence that RNs have actually adjusted grievances. The limited authority exercised by charge nurses to resolve interpersonal conflicts among employees does not confer supervisory status. ***St. Francis Medical Center-West***, 323 NLRB 1046, 1047-48 (1997).

For every task performed by an RN, there is a very specific policy and procedure in writing. These procedures are available for review by the RNs in their work area; however, some of the more experienced RNs do not need to refer to the policies and procedures on a regular basis due to their length of experience. The limited authority of RNs to assign discrete tasks to less skilled employees, based on doctor's orders, hospital policy and procedures or standing orders, or what is dictated by their profession, does not require the use of independent judgment in the direction of other employees. ***Ferguson Electric Co.***, 335 NLRB No. 15 (Aug. 24,

2001). The RNs do not evaluate the work of the less skilled employees or ensure that they have completed a task or done so correctly.

The Employer asserts that charge nurses exercise independent judgment when they assign staff nurses to particular patients or beds, by matching the level of experience of the employee with the level of acuity of the patient. However, the Employer has a very detailed written policy for the assignment of patients by charge nurses or assistant clinical managers. Pursuant to this policy, it is the responsibility of clinical managers or assistant clinical managers to ensure adequate staffing levels, and the composition of staff as to skill level when it comes to caring for the patients in a particular unit. Direction as to specific and discrete tasks and even the assignment of employees detailing when and where they are to carry out their duties falls below the supervisory threshold if the use of independent judgment and discretion is supervised by the superior's standing orders and the employer's operating regulations. ***Dynamic Science, Inc.***, 334 NLRB No. 56 (June 27, 2001); ***Chevron Shipping Co.***, 317 NLRB 379, 381 (1995). Furthermore, the weight of the evidence suggests that in practice, the assignments are routine in nature, and are based mainly on principles of fairness and the even distribution of work. ***Byers Engineering Corp.***, 324 NLRB 740 (1997); ***Providence Hospital***, supra; ***Ohio Masonic Home***, supra. For the most part, the schedule is based on the schedule from the previous day, and providing continuity for the patients. Finally, the RNs work together to resolve any problems with patient assignments, based on the very nature of the rotating charge nurse position. A charge nurse assigning a patient to a staff nurse one day, can the next day be assigned a patient from that same staff nurse, when the roles are reversed. A charge nurse also assigns break times for other employees. However, the charge nurse generally sets up the break times in order to ensure coverage on the floor, and receives input from the nursing staff as to when they would like to take their break.

The Employer submits that if RNs are not supervisors, the ratio of nursing supervisors to nursing staff would be preposterous. However, on the other hand, if all staff nurses are found to be supervisors, the ratio of nursing supervisors to nursing staff would be one supervisor for less than every two employees. ***Naples Community Hospital***, 318 NLRB 272 (1995); ***Essbar Equipment Co.***, 315 NLRB 461 (1994); ***Beverly California Corp. v. NLRB***, 970 F.2d 1548, 1550 fn. 3 (6th Cir. 1992). Furthermore, clinical supervisors, assistant clinical managers and/or clinical managers are present or on call 24 hours a day to handle any problems that may arise. Consequently, I find that the RN staff nurses/charge nurses are not statutory supervisors.[14]

[14] Due to the rotating nature of the charge nurse position, the frequency with which each RN serves as a charge nurse varies. Some are permanent charges; some spend nearly half of their time as a charge nurse, and some are hardly ever in charge. Because I find that the charge nurses, whether permanent or rotating, do

5. For the above reasons, and based on the record as a whole, the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within Section 9(b) of the Act.

> All full-time, regular part-time contingent and in-house flex registered nurses at the Employer's facility, Oakwood Heritage Center, located in Taylor, Michigan; but excluding all physicians, technical employees, other professionals, business office clericals, support service employees, skilled maintenance employees, confidential employees, director of surgical services, nursing site leader, clinical nurse supervisor, assistant clinical manager, clinical manager, nurse externs, graduate nurse externs, and all managers, supervisors, and guards as defined in the Act.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan this 4th day of February, 2002.

(SEAL)

/s/ Stephen M. Glasser
Stephen M. Glasser, Acting Regional Director
National Labor Relations Board, Seventh Region
Patrick V. McNamara Federal Building
477 Michigan Avenue, Room 300
Detroit, Michigan 48226

177-8520-0000
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not exercise statutory supervisory authority, the frequency with which a particular nurse may serve as a charge nurse is not controlling.

DIRECTION OF ELECTION

An election by secret ballot shall be conducted under the direction and supervision of the undersigned among the employees in the unit(s) found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those employees in the unit(s) who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military service of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by:

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), AFL-CIO

LIST OF VOTERS[1]

In order to ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. ***Excelsior Underwear, Inc.***, 156 NLRB 1236 (1966); ***NLRB v. Wyman-Gordon Company***, 394 U.S. 759 (1969); ***North Macon Health Care Facility***, 315 NLRB 359 (1994). Accordingly, it is hereby directed that **within 7 days** of the date of this Decision, 2 copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the undersigned who shall make the list available to all parties to the election. The list must be of sufficient clarity to be clearly legible. The list may be submitted by facsimile transmission, in which case only one copy need be submitted. In order to be timely filed, such list must be received in the **DETROIT REGIONAL OFFICE** on or before **FEBRUARY 11, 2002.** No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the **Executive Secretary, Franklin Court, 1099 14th Street N.W., Washington D.C. 20570.** This request must be received by the Board in Washington by: **FEBRUARY 19, 2002**.

Section 103.20 of the Board's Rule concerns the posting of election notices. Your attention is directed to the attached copy of that Section.

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[1] If the election involves professional and nonprofessional employees, it is requested that separate lists be submitted for each voting group.

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
SEVENTH REGION

OAKWOOD HEALTHCARE, INC.[1]
d/b/a OAKWOOD ANNAPOLIS HOSPITAL
Employer

and CASE 7-RC-21970

LOCAL 79, SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO
Petitioner

APPEARANCES:

Ronald J. Santo, William M. Thacker, and Claire S. Harrison, Attorneys, of Detroit, Michigan, for the Employer.
Bruce A. Miller, Attorney, and Bruce Tribble, of Detroit, Michigan, for the Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record[2] in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

[1] The Employer's name appears as corrected at the hearing.
[2] The parties submitted briefs, which were carefully considered.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

The Employer, Oakwood Healthcare, Inc. (OHI) owns and operates a large network of hospitals and related health care enterprises. Its Oakwood Healthcare System (OHS) runs four acute-care hospitals; neighborhood and occupational health care centers; specialty care centers for mammography, cardiac rehabilitation, sports medicine, and adolescent health; numerous foundations; and various ancillary services such as laboratories and pharmacies. The Petitioner wishes to represent a unit of 232 registered nurses employed at a single acute-care hospital, Oakwood Annapolis Hospital (Annapolis). The Employer contends that the smallest appropriate unit consists of 1,872 registered nurses employed at Annapolis and its 3 other acute-care hospitals -- Oakwood Hospital and Medical Center (OHMC), Oakwood Heritage Hospital (Heritage), and Oakwood Seaway Hospital (Seaway). The 4 acute-care hospitals are located in the southwestern suburbs of Detroit within a radius of 22 miles.

There is no history of collective bargaining among the acute-care hospital nurses at issue. However, in 1994 the Board conducted a single-facility representation election, and in 1995 a rerun election, among nurses at Heritage. For many years, OHMC's service and maintenance employees have been represented in a single unit by American Federation of State, County, and Municipal Employees, and OHMC's licensed practical nurses have been represented in a single unit by the Licensed Practical Nurses League. Before OHI closed its behavioral medicine facility known as Annapolis-Westland, nurses there were represented in a single-facility unit by the Petitioner.[3] Since 1967, the service and maintenance employees of Annapolis, Heritage, and Seaway have been represented by the Petitioner in a multi-facility unit.

OHI's president and chief executive officer is Gerald D. Fitzgerald. Directly under him is Joseph Diederich, the chief operating officer, who has overall responsibility for health care delivery at the four acute-care hospitals as well as numerous ambulatory, long-term care, and care management facilities and

[3] Annapolis-Westland is separate and distinct from the hospital known as Annapolis herein.

foundations. Due to the complicated series of transactions by which OHI acquired Annapolis, Heritage, and Seaway, those three acute-care hospitals are still nominally owned by a separate subsidiary corporation, Oakwood United Hospitals, Inc. However, OHI manages those hospitals, leases their real property and physical assets, and employs their staffs. In contrast to the situation prevailing at the time of the 1994 Heritage decision and election, Oakwood United Hospitals, Inc. no longer maintains a separate board or management structure.

Of the four acute-care hospitals, OHMC, by far the largest facility, offers the widest range of services, including but not limited to in-patient mental health, obstetrics, specialized cardiac care, neurosurgery, neonatal intensive care, cancer center, and pediatrics. Neither Annapolis nor Heritage offers obstetrics. Heritage, alone among the four hospitals, has a pain clinic, sleep lab, and in-patient rehabilitation unit. Although each hospital operates its own laboratory to perform emergency tests requiring a result in two hours or less, all routine lab tests are performed at OHMC. OHI supports its hospitals and network health care facilities with centrally handled materials management, laundry, patient billing, medical transcription, accounting, payroll, marketing, public relations, human resources, and risk management services. Each of the acute-care hospitals runs its own kitchen, but certain basic foodstuffs such as gravies and soups are prepared at OHMC and then distributed. All OHI job candidates and employees are tracked in a system-wide computer database called PeopleSoft.

The corporate Human Resources Department is headed by Executive Vice President John Furman, who reports directly to President/CEO Fitzgerald. Under Furman are Corporate Director of Employee and Labor Relations Ed Frysinger and Corporate Director of Compensation and Benefits Dan Smorynski. Director of Employee and Labor Relations Verna Bastedo as well as the currently unfilled directors of staffing and human resources report to Frysinger, while a benefits manager, compensation manager, and pension analyst report to Smorynski. The corporate Human Resources Department has developed and issued standardized personnel forms for virtually all events and actions. It has promulgated uniform attendance, leave, and transfer policies and procedures. With the approval of senior management councils, it has formulated, and when necessary it revises, system-wide fringe benefit packages and wage ranges for every job classification. Local managers must use the prescribed forms and may not depart from the established policies, procedures, benefits, and wages. A common employee handbook summarizing these employment matters applies to workers at the four hospitals as well as other OHS facilities and OHI's home care division.

Director of Employee and Labor Relations Bastedo is OHI's labor contract negotiator. She also supervises human resource personnel at individual sites. Stationed at Annapolis are two human resource clerical employees, one

employment recruiter, and one human resource manager; at Heritage, two human resource clericals, a part-time employment recruiter, and a part-time human resource manager; at Seaway, two part-time human resource clericals, a part-time employment recruiter (shared with Heritage), and a part-time human resource manager (shared with Heritage); and at OHMC, three human resource clericals, five or six employment recruiters, and one human resource director. Bastedo assigns human resource professionals to perform tasks at facilities different from their home base when the need arises. On-site human resource staff members answer questions, direct inquiries, and implement but may not modify corporate employment policies and practices. Except for OHMC, which stores employee personnel files at a corporate office known as Village Plaza, the hospitals maintain their own respective personnel files.

The corporate office of staffing coordinates the recruitment of nurses on a system-wide basis. OHS advertises all job openings throughout its system on OHI's web site and in various print and electronic media. It sends recruiters to job fairs. Nurse recruiters concentrate on assigned geographical areas, but will direct interested applicants to job openings at any site. After completing a standard application form, a job candidate receives an initial screening by a nurse recruiter. This involves a preliminary inquiry into minimum qualifications and a background criminal check. The recruiter sends all candidates who pass this minimum threshold to be interviewed by the clinical manager -- the on-site, first-line supervisory nurse -- into whose unit the candidates seek entry. The interviews conducted by the clinical manager explore the applicants' experience levels and clinical competence. An Employer witness testified that the final hiring choice is normally the product of consensus between the recruiter and clinical manager. As far as the record reveals, however, the recruiter does not participate in the clinical manager's interview regarding specific job qualifications. An Employer exhibit culled from one of many written procedures approved by a multi-site body called the Acute Care Nursing Operations Council states that the clinical manager selects the most qualified candidate and informs the nurse recruiter of the decision.

All employees covered by the handbook described above are subject to the same progressive disciplinary system. For minor infractions, the progression is counseling, a first and second written warning, a three- or five-day suspension, and finally termination. Major infractions may meet with more severe punishment. The nurse's on-site immediate supervisor undertakes the counseling and initiates the warnings. According to the handbook, suspension decisions originate with local nursing management, but must be reviewed by human resource personnel on site in order to assure consistent and equitable treatment. Terminations require the approval of a corporate vice president. The record does not reveal whether, or how often, corporate human resource officials countermand nursing managers' suspension and discharge recommendations. All discipline is

recorded on standard corrective action report forms and filed with the Human Resources Department.

The same employee handbook outlines a problem resolution mechanism for use at the hospitals and elsewhere. Steps one and two of the procedure are meetings between the aggrieved nurse and on-site nursing supervision. Step three involves a human resource representative who may be either based at the aggrieved nurse's hospital or imported from another site. Directors of Employee and Labor Relations Bastedo or Frysinger address grievances at step four. If the dispute arises out of a suspension or termination, impartial arbitration is available as a fifth and final internal step.

The registered nurses' chain of command begins with team leaders and charge nurses, who make patient-care assignments. The first-line statutory supervisors are the assistant clinical managers, operating room (OR) service managers, and pre-admission testing coordinators. Annapolis has 16 assistant clinical managers, 3 OR service managers, and 1 pre-admissions testing coordinator. Next in line are clinical managers, who have general responsibility over particular nursing units. Annapolis has 7 clinical managers. Clinical managers report to clinical nurse supervisors, who oversee the nursing care provided on a given work shift. Annapolis has 6 clinical nurse supervisors. The most authoritative nursing official at each of the hospitals is the nursing site leader (sometimes also called director of patient care services). Annapolis's nursing site leader is Kathleen Cronin. Each nursing site leader reports dually to her hospital's site administrator -- at Annapolis, Chief Administrative Officer Tom Kochis -- and to the corporate chief nursing officer, currently Interim Chief Maria Strom.[4] Strom superintends nursing practice across the entire OHI system, including the acute-care hospitals, the ambulatory and long-term care facilities, and the home care network. The parties stipulated, and I concur, that the individuals occupying positions at the level of assistant clinical manager and higher are statutory supervisors with authority to exercise indicia of authority as set forth in Section 2(11) of the Act. Accordingly, the 232 nurses at Annapolis are supervised by a supervisory/management staff of 34.

All registered nurses at the hospitals report directly to on-site nursing supervisors. With the recent advent of "service line" reporting configurations, however, the upper reach of supervisory hierarchy for nurses in certain specialties includes individuals who oversee that nursing specialty at more than one site. Nonetheless, the development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader. A

[4] The Employer asserts, without record citation, that the nursing site leader reports only to the corporate chief nursing officer and not her site administrator. (Br. 30-31) That the nursing site leader reports to both is reflected in at least two exhibits regarding organizational structure.

communication chain of command is contained in several written directives issued by the corporate Human Resources Department and approved by the Acute Care Nursing Operations Council. These policies specify that a nurse or charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor. The latter contacts the nursing site leader, who consults with the site administrator, service line leader, or risk manager as deemed necessary.[5]

Staffing and scheduling guidelines emanate from the corporate Human Resources Department. These precepts are further refined by the Acute Care Nursing Operations Council. The work schedule for nurses on each nursing unit must be posted for four weeks. The corporation has adopted what is considered a standard work day, and also offers nurses the option of working alternative schedules. Within these parameters, specific choices of unit shifts (days, evenings, midnights, or rotation) and hour patterns (4-hour, 8-hour, 10-hour, or 12-hour) are established by the unit's clinical manager. Requests for shift changes must be made in writing and submitted to the clinical manager. Employees may adjust their schedules by trading with colleagues, but all trades must be requested of and approved in advance by the clinical manager. The amounts of allotted vacation time, sick leave, and personal time are centrally prescribed, but specific requests for vacation time and other leave are submitted to and acted upon by the nurse's immediate site supervisor. In particular, the clinical manager sets the limit on the number of simultaneous vacations that she will allow.

OHS enforces an across-the-board policy forbidding mandatory overtime, but overtime will be scheduled and offered in emergencies. The clinical manager or clinical nurse supervisor determines whether an emergency exists, and all overtime must be approved in advance by those individuals. The corporation has a uniform attendance program that correlates discipline with the number of unexcused absences. The clinical manager has discretion to characterize an "emergency" absence as excused and an undocumented absence as unexcused.

Staffing guidelines are centrally determined, and are based on prescribed criteria such as patient census and acuity. The clinical nurse supervisor is responsible for assuring that adequate staff is available and for initiating the use of overtime, system or in-house flex pool nurses, or outside agency nurses to cover staffing shortages. Each hospital's nursing site leader maintains 24-hour accountability and availability to assure that appropriate staffing levels are continuous.

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[5] Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines." It is clear that out of a nursing staff at Annapolis of 232, 65 to 70 nurses are in "service lines."

An inter-site nursing leadership council has devised detailed job descriptions for each nursing position. As noted above, each job has a set wage range from which site managers may not vary. A newly hired or transferred nurse is assigned a wage rate within the range based upon her level of experience, in accordance with a centrally determined grid. How years of experience for this purpose are counted or weighted is not disclosed in the record. The wage ranges for each job classification are uniform across the four acute-care hospitals.

All employees subject to the handbook receive periodic performance appraisals, prepared by immediate site supervisors on centrally prescribed forms. The supervisor assigns a numerical rating in specific areas, and the individual ratings are converted, in accordance with a predetermined formula, into an overall score. As stated in the handbook, all employees with a final score of 100 or more are entitled to whatever across-the-board pay increase that the Employer chooses to implement. Any applicable pay increase will be the same for all eligible employees, regardless of the exact appraisal score.

The handbook states that OHS encourages inter-corporate voluntary job transfers as a way for employees to seek personal advancement. All employees with six months' seniority in their present position, who have been free of disciplinary suspensions within the last two years, are eligible for a voluntary transfer. A nursing site leader may grant an exception to the six-month requirement. A nurse initiates a voluntary transfer by completing a transfer request form and submitting it to the Human Resources Department. The clinical manager of the unit being requested receives a copy of such request. As a position becomes available, the clinical manager interviews all applicants who meet the foregoing minimal requirements. Prior to making her decision, the clinical manager of the receiving unit will request background information from the transferring clinical manager. The receiving clinical manager makes the final selection, utilizing defined clinical criteria. A nurse who transfers to a new site may carry her accumulated sick and vacation time, but not unused holidays or personal days. Her length of service will follow her to the new site for the purpose of determining eligibility for service awards, vacation, sick time, and health benefits.

Nurses normally may not use their corporate seniority to "bump" into the position of a less senior nurse at a different site. Such bumping is theoretically permitted only in the case of a reduction of force *and* if the two nurses are in the same service line. Whether these twin conditions have ever been met so as to trigger an occasion of bumping was not disclosed in the record.[6]

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[6] The Employer's closure of the Annapolis-Westland behavioral health facility in 1997 affected 20 nurses. According to Verna Bastedo, their unionized status meant that OHS' bumping procedures did not apply. Nonetheless, 13 of the 20 nurses were offered jobs in OHS' acute-care hospitals. Obstetric units in Seaway

During the 14.5 month period preceding the hearing in this case, 9 nurses permanently transferred from Annapolis to another OHS acute-care hospital, and 24 nurses permanently transferred to Annapolis. In relation to the 232-nurse complement at Annapolis, this is a transfer rate of 14%. Of the 24 in-coming transfers, 14 were occasioned by the closing of Beyer Hospital, an acute-care facility formerly part of Oakwood United Hospital, Inc. The record does not reveal the reason for the other Annapolis transfers, or whether they were voluntary or involuntary. If the Beyer closing did not occur during the selected time span, Annapolis's transfer rate would be 8%.

During the same period, 24 nurses made permanent transfers among OHMC, Seaway, and Heritage. In addition, OHMC, Seaway, and Heritage also absorbed 23 nurses due to OHI's closing of Beyer Hospital. Excluding the Beyer transfers as non-recurring events yields a transfer rate among OHMC, Seaway, and Heritage of less than 1.5%.

During the 5-month period ending shortly before the hearing, there were 7 temporary transfers of nurses from other OHS hospitals into Annapolis, and 63 temporary transfers of Annapolis nurses to other hospitals. The intervals of time spent working at the outside site varied; most exceeded eight hours. The preponderance of such temporary transfers was due to the assignment of flex pool staff, nurses who receive premium pay in exchange for working flexible schedules. The reasons for these temporary transfers were not explored at the hearing.

Other than the contact occasioned by the transfers described above, nurses from one site may encounter nurses from another during the corporate stage of new employee orientation. This program, which follows a uniform syllabus, takes place at a central corporate office and is attended by all newly hired nurses. Nurses also receive site-specific orientation upon being hired or transferred.

Congress instructed the Board to make unit findings so as "to assure to employees the fullest freedom in exercising the rights guaranteed by this Act." 29 U.S.C. §159(b). It is axiomatic that nothing in the Act requires a bargaining unit to be the *only*, or the *ultimate*, or the *most appropriate* grouping. ***Overnite Transportation Co.***, 322 NLRB 723 (1996); ***Capital Bakers***, 168 NLRB 904, 905 (1967); ***Morand Bros. Beverage Co.***, 91 NLRB 409 (1950), enfd. 190 F.2d 576 (7th Cir. 1951). A union need not seek representation in the most comprehensive grouping of employees unless an appropriate unit compatible with the union's

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and Beyer, a now defunct facility, also closed in recent years. There is testimony that affected nurses were absorbed into the corporate system and retained their seniority, but no indication that they displaced other nurses via bumping.

request does not exist. ***Purity Food Stores***, 160 NLRB 651 (1966); ***P. Ballantine & Sons***, 141 NLRB 1103 (1963). A union's desire is always a relevant, although not a dispositive, consideration. ***E. H. Koester Bakery & Co.***, 136 NLRB 1006 (1962).

A single facility of a multi-location employer is a presumptively appropriate unit. ***Hegins Corp.***, 255 NLRB 160 (1981). The Board, with court approval, uses the same single-facility presumption in fashioning health care units. ***Manor Healthcare Corp.***, 285 NLRB 224 (1987); ***Presbyterian University Hospital v. NLRB***, 88 F.3d 1300, 1309 (3rd Cir. 1996); ***Staten Island University Hospital v. NLRB***, 24 F.3d 450, 456-467 (2nd Cir. 1994).

Manor Healthcare mandates consideration of traditional factors in deciding whether the presumption has been overcome. Such factors are geographic proximity, bargaining history, employee interchange and transfer, functional integration, administrative centralization, and common supervision. Thus, the presumption is normally overcome only if employees from the single location have been blended into a wider unit by bargaining history, or if the single location has been so integrated with a wider group as to cause it to lose its separate identity. ***Heritage Park Health Care Center***, 324 NLRB 447, 451 (1997), enfd. 159 F.3d. 1346 (2nd Cir. 1998); ***Passavant Retirement & Health Center***, 313 NLRB 1216 (1994); see also ***Centurion Auto Transport***, 329 NLRB No. 42 (1999). The presumption may also be rebutted in the health care setting by a showing that approval of a single-facility unit will increase the kinds of disruptions to continuity of patient care that Congress sought to prevent in cautioning against proliferation of units in the health care industry. ***Mercywood Health Building***, 287 NLRB 1114, 1116 (1988), enf. denied on other grounds sub. nom. ***NLRB v. Catherine McAuley Health Center***, 885 F.2d 341 (6th Cir. 1989).

OHI has undertaken a number of measures to streamline its enterprises. This has resulted in centralization of many administrative functions, including marketing, purchasing, recruitment, payroll, and human resources. Wages, benefits, and disciplinary procedures exhibit a high degree of uniformity. The advent of service lines affects the reporting structure by making certain mid- and high- level nursing supervisors responsible for coordinating nursing services at more than one facility.

Nonetheless, each nurse at Annapolis reports to a supervisor on site, and on-site management still exercises significant autonomy over the Annapolis nurses' quotidian work lives. Clinical managers (or their on-site service line equivalent) control work schedules, choice of shifts, and hours. They grant or deny leave requests, determine how many vacations will be permitted at a time, and decide whether overtime will be worked. Site supervisors interview and select

new hires and transferees from pools of eligible nurses. A clinical manager has some discretion in the classifying of an absence as excused or unexcused.

Site supervisors initiate all disciplinary actions, and, as far as the record reveals, take conclusive unilateral action with respect to counseling and written warnings. Similarly, site supervisors have the authority to resolve grievances at the first two steps of the dispute resolution procedure. A nurse's job performance appraisal by her site supervisor determines her eligibility for any across-the-board wage increase. When professional, operational, and ethical problems arise, nurses are specifically instructed to adhere to a chain of command that originates at the first level of nursing management at the site, the clinical manager, and travels through the site's hierarchy to the nursing site leader.

The foregoing recital demonstrates that within OHI's framework, Annapolis nurse management retains significant authority. The presence of local control is a decisive factor and overcomes even strong evidence of centralization. ***NLRB v. HeartShare Human Services of New York, Inc.***, 108 F.3d 467 (2nd Cir. 1997), enforcing 317 NLRB 611 (1995) (finding single facility appropriate). In ***RB Associates***, 324 NLRB 874 (1997), the Board, relying in part on the existence of local supervision, found a single hotel unit to be appropriate, despite the close proximity of other hotels; common personnel policies, handbook, benefits, rules, and regulations; central hiring; commonly conducted orientation; intercession of a corporate human resource director in hiring, discipline, and performance evaluations; identical employee skills and functions; and open transfers without loss of benefits or seniority. See also ***Children's Hospital of San Francisco***, 312 NLRB 920 (1993), enfd. sub. nom. ***California Pacific Medical Center v. NLRB***, 87 F.3d 304 (9th Cir. 1996).

Annapolis is a discrete facility, geographically separated from the other acute-care hospitals. It is 8 miles away from Heritage, 10 from OHMC, and 22 miles distant from Seaway. Compare ***NLRB v. Catherine McAuley Health Center***, supra at 347-348 (single-facility presumption inapplicable because sought unit, formerly geographically distant, has been physically relocated to central campus); ***Lutheran Welfare Services of Northern Pennsylvania***, 319 NLRB 886 (1995) (facilities only 100-200 feet apart separated by parking lot). There is no relevant bargaining history in this case militating against the appropriateness of a single-facility finding.

The evidence does not show, nor does OHI contend, that a single-facility unit finding will threaten the continuity of patient care. ***Hartford Hospital***, 318 NLRB 183, 193 (1995), enfd. 101 F.3d 108 (2nd Cir. 1996).

The evidence of interchange in the instant case is limited. The majority of permanent transfers in the period under examination was caused by the closure of an acute-care hospital, a relatively rare event. The remaining permanent transfers were statistically negligible in the overall unit sought by OHI, and hardly decisive at Annapolis. Many more temporary transfers were attributable to the use of flex pool nurses than to migration of the stationary nursing corps.

I find the cases relied upon by the Employer to be distinguishable. In ***West Jersey Health System***, 292 NLRB 749 (1989), the Board had a concern, absent here, that unit fragmentation would adversely affect patient care services. The record in ***West Jersey*** also demonstrated considerably more employee interchange, with 147 permanent transfers in a 14-month period, regular temporary rotation of unit employees to other facilities, and the availability of seniority bumping rights.[7] In ***Presbyterian/St. Luke's Medical Center***, 289 NLRB 249 (1988), the Board found that a "significant number" of transfers had occurred and that physicians need not make separate applications, as they do here, to be admitted to practice. In ***Montefiore Hospital***, 261 NLRB 569 (1982), neither party sought a single-facility unit, and the Board's task was to delineate an appropriate unit among competing multi-location groupings.

OHI has adduced evidence tending to show that a unit comprised of its four acute-care hospitals may be appropriate. However, that a wider unit may be appropriate does not imply that a narrower one is inappropriate. ***Children's Hospital of San Francisco***, supra at 928. OHI bears the burden of establishing that consolidation and centralization have destroyed Annapolis's identity. For the reasons discussed above and based upon the entire record, I find that OHI has not met that burden.

Accordingly, I find that the following employees of the Employer constitute a unit appropriate for purposes of collective bargaining within the meaning of Section 9(b) of the Act, and I hereby direct an election therein:

> All full-time and regular part-time registered nurses employed by the Employer at its Oakwood Annapolis Hospital facility in Wayne, Michigan, including in-house flex pool and contingent nurses,[8] staff nurses, RN first assistants, staff nurse anesthetists, cardiac cath lab

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[7] In *West Jersey*, employees could transfer by exercising bumping rights. At OHI, no voluntary transfers may be accomplished by bumping. Rather, seniority may be exercised on an inter-site basis only within the same service line during a reduction in force.

[8] The parties stipulated to the eligibility of in-house flex pool and contingent nurses who have worked at least 72 hours in the quarter immediately preceding the election eligibility date. Based on the record, and in conformity with a similar stipulation and finding in the 1994 Heritage decision, I adopt this stipulation. The parties stipulated to the ineligibility of system flex pool nurses. Based on the record and community of interest factors, I concur in this stipulation.

nurses, clinical educators, and case managers; but excluding nursing site leaders, clinical managers, assistant clinical managers, clinical nurse supervisors, OR service managers, pre-admission testing coordinators, system flex nurses, home care nurses, all other employees, and guards and supervisors as defined in the Act.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan, this 9th day of May, 2001.

(SEAL)

/s/ William C. Schaub, Jr.
William C. Schaub, Jr., Regional Director
National Labor Relations Board, Region Seven
Patrick V. McNamara Federal Building
477 Michigan Avenue, Room 300
Detroit, Michigan 48226

440-1720-0133

DIRECTION OF ELECTION

An election by secret ballot shall be conducted under the direction and supervision of the undersigned among the employees in the unit(s) found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those employees in the unit(s) who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military service of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by:

LOCAL 79, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

LIST OF VOTERS[1]

In order to ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. ***Excelsior Underwear, Inc.***, 156 NLRB 1236 (1966); ***NLRB v. Wyman-Gordon Company***, 394 U.S. 759 (1969); ***North Macon Health Care Facility***, 315 NLRB 359 (1994). Accordingly, it is hereby directed that **within** 7 **days** of the date of this Decision, copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the undersigned who shall make the list available to all parties to the election. The list must be of sufficient clarity to be clearly legible. The list may be submitted by facsimile transmission, in which case only one copy need be submitted. In order to be timely filed, such list must be received in the **DETROIT REGIONAL OFFICE** on or before **MAY 16, 2001.** No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the **Executive Secretary, Franklin Court, 1099 14th Street N.W., Washington D.C. 20570.** This request must be received by the Board in Washington by: **MAY 23, 2001.**

Section 103.20 of the Board's Rule concerns the posting of election notices. Your attention is directed to the attached copy of that Section.

DIRECTION OF ELECTIONS

[1] If the election involves professional and nonprofessional employees, it is requested that separate lists be submitted for each voting group.

Charge Nurse Policy
Draft

Purpose: To provide the staff RN with guidelines for the Charge RN role.

Role requirements: RN with one year nursing experience. Must possess good communication, organization, problem solving and prioritization skills. A Service First attitude is necessary.

Procedure:
The Charge RN will:

1. Be responsible for staff assignments, bed assignments, and breaks/lunches for staff.
2. Be responsible for narcotic sheets every shift.
3. Keep the unit in compliance to regulatory requirements.
4. Have a broad knowledge of the patients on their units.
5. Be present at shift report and rounds (if applicable).
6. Create and nurture relationships with other disciplines including physicians.
7. Maintain their unit's Charge RN book by entering data for falls and restraints.
8. Be assigned other tasks as appropriate by unit Clinical Nurse Managers.

IMC CHARGE NURSE RESPONSIBILITIES

1. Make daily pt assignments to RN's. LPN's and NA and Secretary.
2. Assign break times for all staff members and provide coverage as needed.
3. Cover LPN's IV medications and co-sign all phone orders for LPNs.
4. Check pt.'s charts to ensure documentation of daily weights by NA's.
5. Facilitate Nursing rounds on Tuesdays and Thursdays.
6. Facilitate admissions. discharges and transfers, so they occur timely.
7. Assist staff with contacting Doctors for pt orders, change in condition of pt. etc.
8. Remember, you are the first step in the chain of command.
9. Perform Data collection responsibilities each shift.
10. Perform acuity sheet at the end of each shift and document on Acuity log.
11. Make sure all QAR's are filled out and appropriate personnel notified.
12. Observe Cardiac Monitors for arrythmias and assist with appropriate treatment.
13. Report off to oncoming Charge Nurse who has received admissions/transfers.

5-A

Case No. JRC 22141 Official Exhibit No. EMP 5 (A-D)

Disposition: Rejected Identified X Received X

IN THE MATTER OF: OAKWOOD

Date: 1-9-02 Witness: THOISEN Reporter: DD

Oakwood Heritage Hospital
MSW Charge Nurse Responsibilities

1. Assigns patient care assignments according to staff's job description, competency, and patient's acuity.

2. Documents assignments in "Log Book."

3. Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel.

4. Assigns break/lunch periods.

5. Assures "Patient Acuity" forms are completed and reported to supervisor two hours prior to start of next shift.

6. Assists Clinical Manager/designee with QA/QI activities

7. Assures that the responsibility of narcotic count between shifts is completed.

8. Informs Clinical Manager/designee of any acute changes in patient status.

9. Informs Clinical Manager/designee of any problems that are encountered on unit.

10. Correlates bed assignments of newly admitted and/or transferred patients with Bed Control (with regard to patient age, status, and diagnosis).

11. Assures that crash cart is inspected for: properly functioning defibrillator, charged battery, verification of lock, and availability of appropriate equipment (located on top and side of cart).

12. Assist co-workers as needed to promote continuity and flow on unit - champion and encourage team approach to patient care.

5.6

NICHE

Oakwood Heritage Hospital
MSE Geriatric Registered Nurse (GRN) Responsibilities

1. Assigns patient care assignments according to staff's job description, competency and patient's acuity.

2. Documents assignments in "Log Book."

3. Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel.

4. Assigns break/lunch periods.

5. Assures "Patient Acuity" forms are completed and reported to supervisor two hours prior to start of next shift.

6. Assists Clinical Manager/designee with QA/QI activities (D/C data, Fall data, FIM data, etc).

7. Monitors DSPICES; consult creation.

8. Assures that the responsibility of narcotic count between shifts is completed.

9. Informs Clinical Manager/designee of any acute changes in patient status.

10. Informs Clinical Manager/designee of any problems that are encountered on unit.

11. Correlates bed assignments of newly admitted and/or transferred patients with Bed Control (with regard to patient age, status, and diagnosis).

12. Assures that crash cart is inspected for: properly functioning defibrillator, charged battery, verification of lock, and availability of appropriate equipment (located on top and side of cart).

13. Assist co-workers as needed to promote continuity and flow on unit - champion and encourage team approach to patient care.

5-C

OAKWOOD HOSPITAL
HERITAGE CENTER TAYLOR

NURSING SERVICES/III

POLICY/PROCEDURE

IMPLEMENTATION 8/89

REVISION 7/90, 6/93, 6/94

REVIEWED 1/95, 5/96, 8/99

APPROVED BY

BRENDA THEISEN RN

TITLE

UNIT GUIDELINE:
CHARGE NURSE
RESPONSIBILITIES

I PURPOSE Responsibilities of the Charge Nurse defined.

II EQUIPMENT

III GENERAL INFORMATION

3.1 Policy

A Charge Nurse assignments will be made by the Nurse Manager or designee in SCU. On assigned day, Charge Nurse will not be "pulled" to any other zone, however, will be added to next pull rotation.

B Charge Nurse will have demonstrated competency in fulfilling these duties.

IV PROCESS

4.1 Procedure - The Charge Nurse will:

A Determine patient care assignments for RN, LPN, GN, NE, and NA with consideration to staff capabilities/competence.

B Note the patient assignment in the Unit Shift Log Book.

C Assign RN coverage for LPN, NE and GN.

D Assign breaks and lunches to maintain adequate patient coverage.

E Assess and record patient acuity.

F Assign code blue beeper to staff.

G Check the crash cart or assign duty.

H Charge Nurse will inform Nurse Manager/Assistant Nurse Manager or designee of any acute changes in the patient's condition, admissions or discharges from the unit.

I Assigns admissions/transfers to staff members.

J Reviews charge sheets for completeness.

5-D

Oakwood

Effective Date: 8/99
Supersedes Policy Dated: 2/82

- ☐ OHS
- ☐ OH & Medical Center-Dearborn
- ☒ OH Heritage Center
- ☐ OH Annapolis
- ☐ OH Beyer Center
- ☐ OH Seaway Center
- ☐ Ambulatory_____
- ☐ LTC_____
- ☐ Department_____
- ☐ Other_____

TITLE: ASSIGNMENT (PATIENTS)

I. PURPOSE

To provide guidelines for determining patient care assignments.

II. EQUIPMENT

Acuity reports
Competency Logs
Shift to shift reports
Assignment sheets

III. GENERAL INFORMATION

3.1 POLICY

Decisions for patient care assignments are based on the degree and complexity of care required by the patient and competency of staff to meet those needs.

IV. PROCESS

4.1 PROCEDURE

A. Nursing staff is allocated to the inpatient units by Nurse Manager/Administrative Nursing Supervisor.
B. Assistant Nurse Manager/Charge Nurse (assigned by the Nurse Manager)
- assigns/delegates care needs based on the ability of the patient to do self care, degree of illness, complexity of nursing skills required, and the competency and qualifications of staff.

Assignments section V

Oakwood
Healthcare System

Effective Date:8/15/99
Revised: 6/9/00

OHS	Ambulatory
OH & Medical Center - Dearborn	LTC
OH Heritage	Department
OH Annapolis Center	Other
OH Beyer	
OH Seaway Center	

ASSIGNMENT OF NURSING PERSONNEL
Approved by: Acute Care Nursing Operations Council

I. OBJECTIVE: To establish guidelines for the assignment of nursing personnel and to provide adequate numbers of licensed staff and other personnel to deliver care to patients.

II. GENERAL INFORMATION:

A. An RN must assign the care of each patient to other members of the healthcare team in accordance with the patient's need, and the qualifications and competency of the Nursing staff.

B. The assigned Registered Nurse retains overall responsibility for his/her assigned patients when care is provided by students and/or other non-Oakwood personnel.

C. Patient care assignments are made by the Clinical Manager or the Registered Nurse in charge for that shift. Assignment will be reviewed on an ongoing basis and changes made in response to the patients' changing conditions.

D. The assignment of the patient takes into consideration the acuity level and clinical needs as identified by the Acuity System and the clinical assessment by the Charge Nurse. The patient's acuity is used to determine the level of skill required to care for the patient.

E. A Clinical Supervisor or designee is on duty on all shifts to ensure the immediate availability of licensed staff (including but not limited to the System Flex Pool and the in-house Flex Pool) for bedside care of any patient, in the event of a sudden increase in census and/or acuity. The Supervisor or designee makes rounds on all units, assessing unit activity and acuity, and makes assignments for additional staff based on these, and other, parameters.

F. The Registered Nurse is responsible for the completion of an admission assessment and developing the initial plan of care. Refer to "Admission of a Patient", Policy and Procedure.

G. Delegation of nursing care activities is the responsibility of the Registered Nurse.

H. Sudden changes in acuity or census may require the additional support of licensed and other staff. The Clinical Supervisor or designee must be notified and arrangements made for the assignment of a System Flex RN, a Flex RN, or other staff.

I. Nursing Site Leaders, or designee, maintain 24 hour accountability and availability to ensure continuous appropriate staffing levels and the availability of resources.

III. PROCEDURE:

A. When reviewing the unit schedule, the Clinical Manager may make assignment of unit personnel to specific areas, teams or other responsibilities, such as Charge Nurse.

B. After receiving report, the Charge Nurse and Team Leaders will determine staff assignments.

1. The Charge Nurse will meet with the assigned staff to review patient condition and care activities to be completed for that shift.

2. Specific patient care tasks will be assigned based on competencies and classification of the staff, and care required.

3. All attempts will be made to distribute workload evenly among team members.

4. Special assignments are made at the beginning of the shift, i.e., Code Blue, crash cart checks, lunches and breaks.

C. General considerations for the assignment of staff to patient care.

1. The educational preparation and experience of personnel should meet the patient's requirements, i.e., patients with complicated treatments or requiring frequent assessments for change in status may be assigned to a Registered Nurse, while convalescing patients with minimal treatments or educational needs may be assigned to an LPN under the direction of a RN.

2. Assignment of complex care to people requiring additional supervision should only be made if such supervision is available, i.e., new personnel should be assigned to care activities that can be adequately supervised by identified preceptors.

3. Patients should be assigned based on needs within the group, i.e., workload with the team should be evenly distributed by activities and responsibilities and not strictly numbers of patients. (LPN's may be able to handle larger number of patients than the Registered Nurse who is caring for more complex patients or who has additional responsibilities).

4. Patients should be assigned to nursing personnel so as to provide continuity of care, i.e., a nurse may be assigned to the same group of patients from one day off to another so as to change assignments no more than necessary.

5. Assignments should be made in such a way as to avoid cross-contamination, i.e., patients with known infections should not be assigned to the same person who is caring for patients who have open wounds, are immunosuppressed or are receiving medications which result in immunosuppression. There are other patient conditions that restrict assignments. These can be seen in the Infection Control guidelines.

6. Assignments must be flexible and allow for changes in patients' conditions.

7. Other considerations for assignment:
   a. The Clinical Manager/Charge Nurse should view other activities for the shift and make appropriate assignments.

   b. Such activities include the following:
      1) patient care conferences
      2) inservices, workshops
      3) committee meetings

4) unit maintenance activities, such as painting of rooms
5) personnel development - library time

c. Assignments will be recorded on a specific form and will include:
1) date of care
2) specific assignment for each employee
3) resource person for LPN, nurse extern's, NA's
4) any special assignment, i.e., Code Blue, crash cart checks

Oakwood
Healthcare System

Effective Date: 8/15/99
Supersedes Policy Dated: 9/96

OHS	Ambulatory
OH & Medical Center - Dearborn	LTC
OH Heritage	Department
OH Annapolis Center	Other
OH Beyer	
OH Seaway Center	

CHAIN OF COMMAND: NURSING
Approved by: Acute Care Nursing Operations Council

I. OBJECTIVE: To provide a mechanism for the nursing staff to communicate and resolve issues/concerns.

II. GENERAL INFORMATION:

When a nurse encounters a problem he/she is unable to resolve, (i.e., in rendering patient care; carrying out a physician's order in a timely manner such as lab work, x-rays; treatments not being done; or not being able to procure needed equipment) the chain of command will be instituted.

III. PROCEDURE:

Process of Chain of Command:

1. Nursing staff member communicates verbally and/or in writing of a concern/issue to charge nurse and/or Clinical Manager/Clinical Supervisor.

2. If unable to resolve, the nurse manager/supervisor will contact the Nursing Site Leader.

3. If unable to resolve, the Nursing Site Leader will contact the Administrator/Service Line Leader/Risk Management, as deemed necessary. Situations requiring notification of the Administrator on call are, but not all inclusive:
   a. disaster (fire, severe weather; may be internal and/or external).
   b. medical staff events needing assistance.
   c. media contacts (TV, radio, etc.).

d. request by a significant third party (i.e., patient, family and/or physician requests, Administrator(s) of another Oakwood facility/hospital).

e. any incident or situation that would have a significant impact on the site/organization.

CHECKLIST R CHARGE NURSE ORIENTATIC

NAME: Hudok Pam

UNIT: 2 East

SHIFT: 7-3 3rd p

MANAGER: Monroe, RN

DATE: 1-96

The above named has successfully performed the following responsibilities required of a Charge Nurse:

[✓]YES [ ]NO Assigns patient care assignments according to staffs job descriptions.

[✓]YES [ ]NO Documents assignments in log book.

[✓]YES [ ]NO Assigns coverage and delegates appropiate responsibilities for GN, LPN and Nurse Extern.

[✓]YES [ ]NO Assigns breaks and lunches.

[✓]YES [ ]NO Assures Patient Classification Forms are completed and sent to Information Systems on time.

(NA) [ ]YES [ ]NO Assigns Code Beeper in ICU and Beeper in Behavioral Medicine.

[✓]YES [ ]NO Assists Nurse Manager with QA?QI activities.

[✓]YES [ ]NO Assures that the responsibility of narcotic count between shifts is completed.

[✓]YES [ ]NO Informs Nurse Manager or designeee of any acute changes in patient status.

[✓]YES [ ]NO Informs Nurse Manager of designee of any problems that are encountered on thier unit.

[✓]YES [ ]NO Correlates bed assignments of newly admitted patients with admitting and patient diagnosis.

[✓]YES [ ]NO Reorders necessary supplies for units optimal functioning.

[✓]YES [ ]NO Assures that crash cart is inspected for properly functioning defibrillator, batteries are charged, lock verification and appropiate equipment is located on top and sides.

Signature/Title: Monroe RN - NM

Signature/Title: _____

Clinical Supervisor / Nurse Manager / Assistant Clinical Manager to Staff Ratios

DAY	DATE	EVENINGS	DAYS	MIDNIGHTS
Sunday	November 18	3:84	1:80	1:52
Monday	November 19	3:89	7:91	1:52
Tuesday	November 20	4:81	8:89	1:53
Wednesday	November 21	3:81	5:86	1:55
Thursday	November 22	1:71	1:76	1:51
Friday	November 23	1:77	4:80	1:48
Saturday	November 24	2:79	1:78	1:54
Sunday	November 25	1:80	1:74	1:53
Monday	November 26	3:79	5:83	1:52
Tuesday	November 27	4:79	6:81	1:53
Wednesday	November 28	2:80	8:81	1:54
Thursday	November 29	2:78	7:87	1:53
Friday	November 30	1:73	7:83	1:50
Saturday	December 1	1:80	1:77	1:52
Sunday	December 2	3:73	1:77	1:52
Monday	December 3	2:83	5:80	1:50
Tuesday	December 4	4:84	8:92	1:58
Wednesday	December 5	1:86	6:88	1:57
Thursday	December 6	1:78	7:83	1:56
Friday	December 7	2:77	6:84	1:52
Saturday	December 8	1:72	1:75	2:52

Case No. 7RC 22141

Official Exhibit No. EMP 9

Disposition: Identified X
Rejected Received X

IN THE MATTER OF:
OAKWOOD

Date: 1-9-02 Witness: THEISEN

Reporter: DD

NATIONAL LABOR RELATIONS BOARD

SEVENTH REGION

In the Matter of:

OAKWOOD HEALTHCARE, INC.,

Employer,

and Case No. 7-RC-22141

INTERNATIONAL UNION UNITED AUTOMOBILE AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW,

Petitioner.

_____/

William M. Thacker
Claire S. Harrison
DYKEMA GOSSETT PLLC
Representatives of Oakwood Healthcare, Inc.
315 E. Eisenhower Parkway, Ste. 100
Ann Arbor, MI 48108
(734) 214-7646

_____/

PROOF OF SERVICE

STATE OF MICHIGAN)
)ss
COUNTY OF WASHTENAW)

Ronda Copperstone, an employee of DYKEMA GOSSETT PLLC, being first duly sworn, deposes and says that on the 18th day of February, 2002, she caused to be served a copy of Employer's Request for Review and this Proof of Service upon Regional Director, National Labor Relations Board, Region 7, 477 Michigan Ave., Room 300, Detroit, MI 48226, and Blair

K. Simmons, International Union, UAW, 8000 E. Jefferson Avenue, Detroit, MI 48214, via overnight courier.

Ronda Copperstone

Subscribed and sworn to before me
this 18th day of February, 2002

Notary Public

SHIRLEY L. GOODMAN
NOTARY PUBLIC WASHTENAW CO., MI
MY COMMISSION EXPIRES Jun 16, 2003

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ID\ WMT